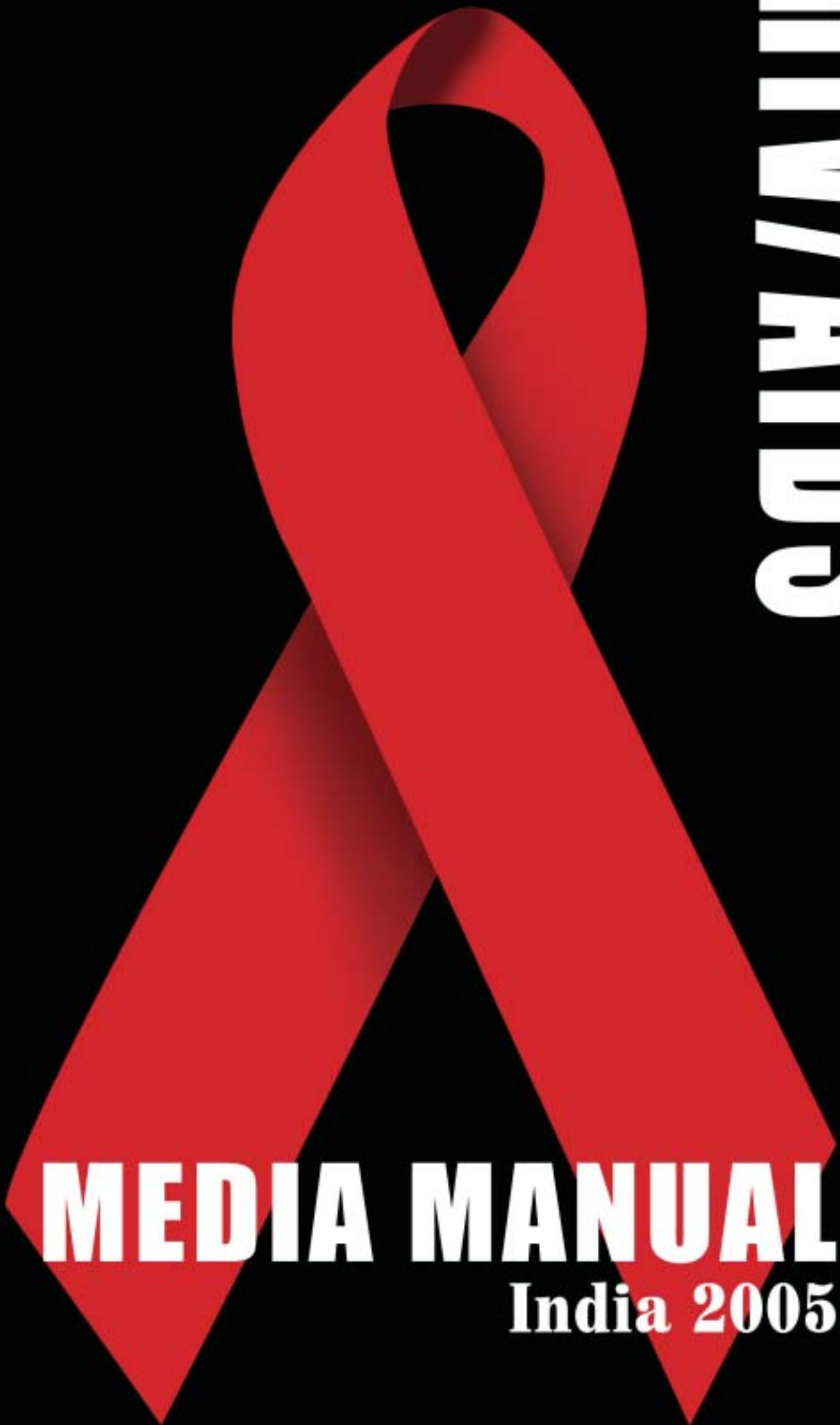

HIV/AIDS

MEDIA MANUAL

India 2005

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India 2005

THE EU-INDIA MEDIA INITIATIVE ON HIV/AIDS

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under
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INTRODUCTION

THE EU-India Media Initiative on HIV/AIDS aims to promote good media practices and favourably impact coverage of the many issues that surround HIV/AIDS.

Too often, reporters shy away from covering HIV/AIDS in depth because they aren't adequately prepared. Admittedly, the subject can be intimidating—it seems to consist of abstruse technicalities enveloped in an environment of fear, prejudice, denial, cultural issues, and even political considerations. And, of course, sensitivities are high.

This Media Manual intends to demystify the subject, set out a roadmap for the uninitiated reporter, and provide fresh inputs to those already covering HIV/AIDS. The chapters address basics, the epidemic, updates on recent happenings, and several tools for reporters—ethical considerations, appropriate language, analytical frameworks, and story topic ideas.

The Initiative is being undertaken by The Thomson Foundation with the financial assistance of the European Union. The Foundation's partners in the project are: the Indian Network of People Living with HIV/AIDS (INP+), Commonwealth Broadcasting Association, and the Jean Monnet European Centre for Excellence, which is part of the University of Tampere in Finland.

Journalists work under a variety of pressures—deadlines and competition among them—and this Manual aims to make their task a little bit easier. If reporting on HIV/AIDS in India can be scaled up a notch and the millions of PLWHA in the country accorded more dignity as a result of this Manual, we will consider our task rewarded.

i am 31.
i have a successful career.
i enjoy music.
i like to workout at the gym.
i miss my flights sometimes.
i am also HIV Positive for the last 11 years.
INDIAN NETWORK
FOR PEOPLE LIVING
WITH HIV/AIDS

TACKLING THE BASICS

WHAT IS HIV?

HIV stands for the Human Immunodeficiency Virus. HIV is the virus that causes AIDS. Being infected with HIV does not automatically mean a person has AIDS or is ill.

WHAT IS AIDS?

AIDS, or Acquired Immune Deficiency Syndrome, is the clinical condition that results from long-term infection with HIV. It is fatal. AIDS is the name for the collection of symptoms that result from the immune deficiency caused by HIV. HIV progressively weakens the body's immune defence system, until it is no longer able to fight off infections, many of which would have been otherwise harmless.

IS AIDS A DISEASE?

No, AIDS is not a disease. Rather, it is a syndrome (a group of illnesses). People with AIDS die because they cannot adequately fight an opportunistic infection, such as cancer, malaria, or tuberculosis. People with cellular immune deficiency are more vulnerable to infections that are otherwise rare, including specific types of pneumonia, meningitis, herpes, and cancers such as Kaposi's sarcoma.

IS THERE A CURE FOR AIDS?

No, there is no cure for AIDS. Neither is there at present any vaccine that can prevent HIV infection. Once a person is infected with HIV, there is no anti-viral drug that can permanently rid the body of it.

In the absence of a cure or vaccine, the only methods available to stem the spread of HIV are information, education, and prevention activities to promote changes in behaviour—particularly sexual behaviour—because HIV is largely transmitted sexually.

IS HIV DIFFERENT FROM OTHER VIRUSES?

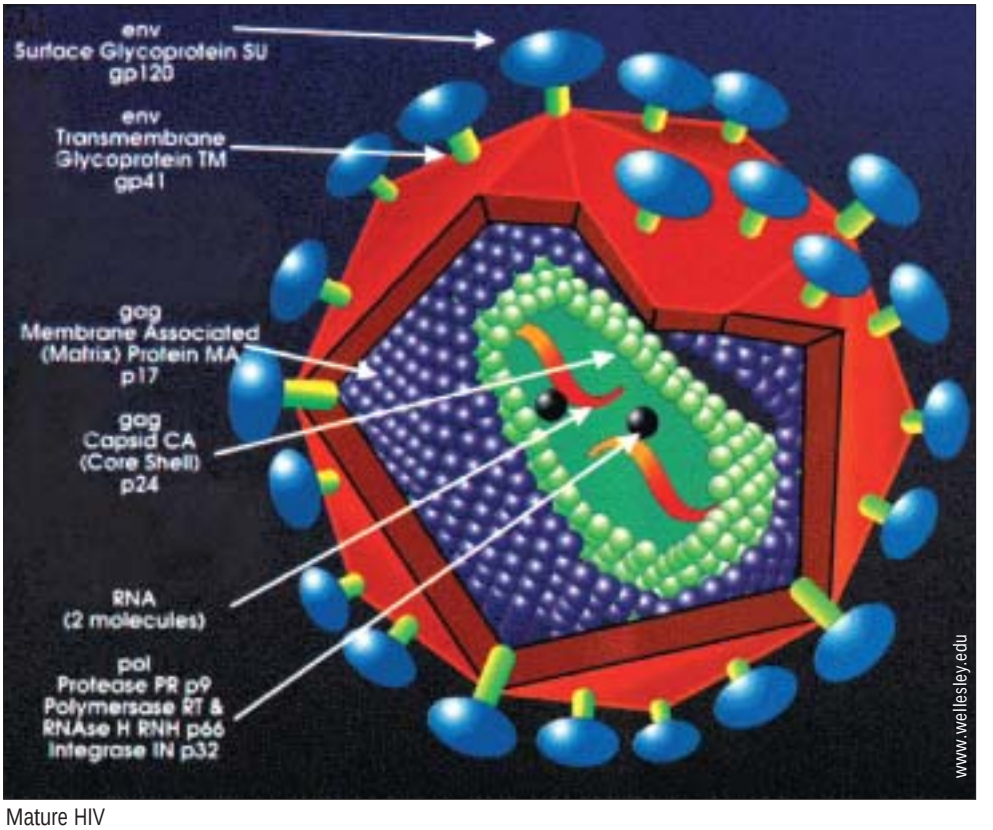
HIV specifically targets key components of the cellular immune system and progressively depletes the body's ability to fight infection. In medical terminology, HIV is a retrovirus—this means it can copy its genetic material, RNA, into DNA using a unique enzyme called reverse transcriptase. Normally, living organisms make RNA out of DNA, but in retroviruses such as HIV, the step is in reverse. HIV inserts its DNA copies into the DNA of the cells of the immune system, turning them into HIV "factories" and preventing them from protecting the body. HIV is also a highly variable virus, which "hides" in other parts of the body such as the lymphatic system and establishes strongholds beyond the reach of the immune system or drugs.

HOW IS HIV TRANSMITTED?

An HIV+ or seropositive person is permanently infected and is permanently infectious to others. HIV is transmitted in semen, vaginal fluid, blood, and breast milk. Transmission mainly occurs in the following ways:

We resolve personally, as well as on behalf of our companies, to use our communications expertise and vast resources to do our part to change the course of this epidemic. We will work together on a coordinated national response to expand public knowledge and understanding about HIV/AIDS.

— INDIAN MEDIA LEADERS
February 2005



Mature HIV

- Through unprotected (without the use of a condom) vaginal or anal sexual intercourse with an infected person. Sexual intercourse accounts for more than 75% of HIV transmission worldwide, according to the WHO;

- Through infected blood in transfusions or blood products;
- From infected blood on contaminated needles, syringes, or other skin-piercing instruments such as are used in injecting drugs; and
- From an infected mother to her child across the placenta before birth, during delivery or through breast milk.

In India, unprotected sexual intercourse is the predominant form of HIV transmission—responsible for more than 85% of all HIV cases, says the National AIDS Control Organization (NACO).

WHAT FACTORS INFLUENCE EASY HIV TRANSMISSION?

The risk of sexual transmission is substantially higher when a person also has an untreated sexually transmitted infection. Risk of transmission is higher in anal intercourse than in vaginal intercourse for the receptive partner. Lesions caused by rough sex or rape increase the probability of HIV transmission.

People with HIV are more infectious to a sex partner during the first few weeks following initial infection with HIV, before the antibodies are produced. They are also more infectious in later phases, when the immune system is no longer able to fight the virus effectively.

HOW IS HIV NOT TRANSMITTED?

HIV does not survive easily outside the human body, so it is not transmitted through toilet seats; by contact such as

hugging, kissing, or shaking hands; by sharing eating or drinking utensils; or by coughing. Neither can it be transmitted through insects such as mosquitoes. Although HIV has been detected in saliva, there is no evidence that anyone has been infected by deep kissing. No cases of HIV transmission have been attributed conclusively to oral sex, but the risk of transmission increases if there are cuts or sores in the mouth.

WHAT IS THE COURSE OF HIV INFECTION?

HIV infection typically follows the following course:

- Primary acute infection;
- A prolonged period without obvious, visible symptoms, although laboratory studies can demonstrate continuous progression of infection; and
- Severe immunodeficiency resulting in secondary opportunistic infections and tumours, which act as the major causes of death in AIDS patients.

WHAT HAPPENS WHEN HIV IS FIRST CONTRACTED?

When a person is first infected by HIV, there is a burst of activity as the virus multiplies and the immune system attempts to battle it by making antibodies. During this period, the viral load (the number of virus particles the body is carrying) is high and the infected person is highly infectious. But a person's HIV status cannot be detected at this stage using standard tests because sufficient antibodies have yet to be formed. This is commonly called the "window period" and lasts from several weeks to about three months.

An infected person will usually experience an episode of illness at the end of the window period, but this often resembles a simple bout of influenza and may pass unnoticed. The symptoms could include lack of energy, fever and night sweats, and diarrhoea over a period of more than a month.

ARE THERE DIFFERENT KINDS OF HIV?

There are two similar HIV viruses, HIV-1 and HIV-2. Both cause clinically indistinguishable AIDS. Both reproduce by using the genetic materials of the cells they invade. Both gradually disable the body's immune system.

However, HIV-2 is less virulent and less infectious than HIV -1. HIV-1 is found throughout the world. HIV-2 is prevalent mostly in West Africa, although it has been detected elsewhere, too. Both HIV-1 and HIV–2 are found in India, but the vast majority of infections here are of the HIV–1, subtype C.

HOW IS HIV DIAGNOSED?

HIV is usually diagnosed by testing for antibodies in the blood.

Infected helper T-cell—the small blue globules are HIV particles

Some Common Acronyms You May Come Across while Reporting on HIV/AIDS

ABC: The ABC of safe sex—Abstinence, Being Faithful, and Consistent and correct use of condoms
ART: Anti-retroviral therapy
ARV: Anti-retroviral drugs

DALYs: Disability adjusted life years

HAART: Highly active anti-retroviral therapy

IDU: Injecting drug user
IEC: Information, education, and communication
INP+: Indian Network of People living with HIV/AIDS

MDGs: Millennium Development Goals (eight goals were developed at the Millennium Summit in September 2000, of which one refers to HIV/AIDS)
MSM: Males who have sex with males
MTCT: Mother to child transmission, also called PTCT

NACO: National AIDS Control Organization, India's nodal body to combat HIV/AIDS

NACP: National AIDS Control Programme
NARI: National AIDS Research Institute (Pune)

PLWHA: People living with HIV/AIDS
PPTCT: Prevention of parent to child transmission
PTCT: Parent to child transmission

STI: Sexually transmitted infection
STD: Sexually transmitted disease

UNAIDS: Joint United Nations Programme on HIV/AIDS
UNDP: UN Development Programme
UNFPA: UN Population Fund

VCT: Voluntary counselling and testing
VCTC: Voluntary counselling and testing centres

WHO: World Health Organization

Antibodies are much easier (and cheaper) to detect than the virus itself, but this is possible only after the end of the window period, when sufficient antibodies are available to be detected by current tests.

It is sometimes possible to detect HIV antigen, i.e. the virus itself, during the window period if, by coincidence, an individual is antigen-tested at this time. After this peak, the level of antigen steeply declines to the point where it is no longer detectable. The level of HIV antigen fluctuates or rises steeply again, usually years later, when the clinical situation of the patient starts to deteriorate with the onset of AIDS.

WHAT ARE THE TESTS THAT DIAGNOSE HIV INFECTION?

The most common method of testing for HIV used today is to test for its antibodies in the blood using a procedure called EIA (enzyme immunoassay) or ELISA (enzyme-linked immunosorbent assay). Because these can give "false positive" results, their findings are usually confirmed with another test, known as the Western Blot test. When the ELISA is used in conjunction with the Western Blot test, the results are more than 99.9% accurate.

Rapid tests for detecting antibodies to HIV exist. They give quick results, usually in 5-30 minutes, as compared to several hours for ELISA. One of the rapid tests available in India is called Tridot.

Many other tests of HIV are available for special purposes, such as for additional testing of blood supply or for research, but they are not in common use either because they are expensive or require sophisticated equipment and specialized training.

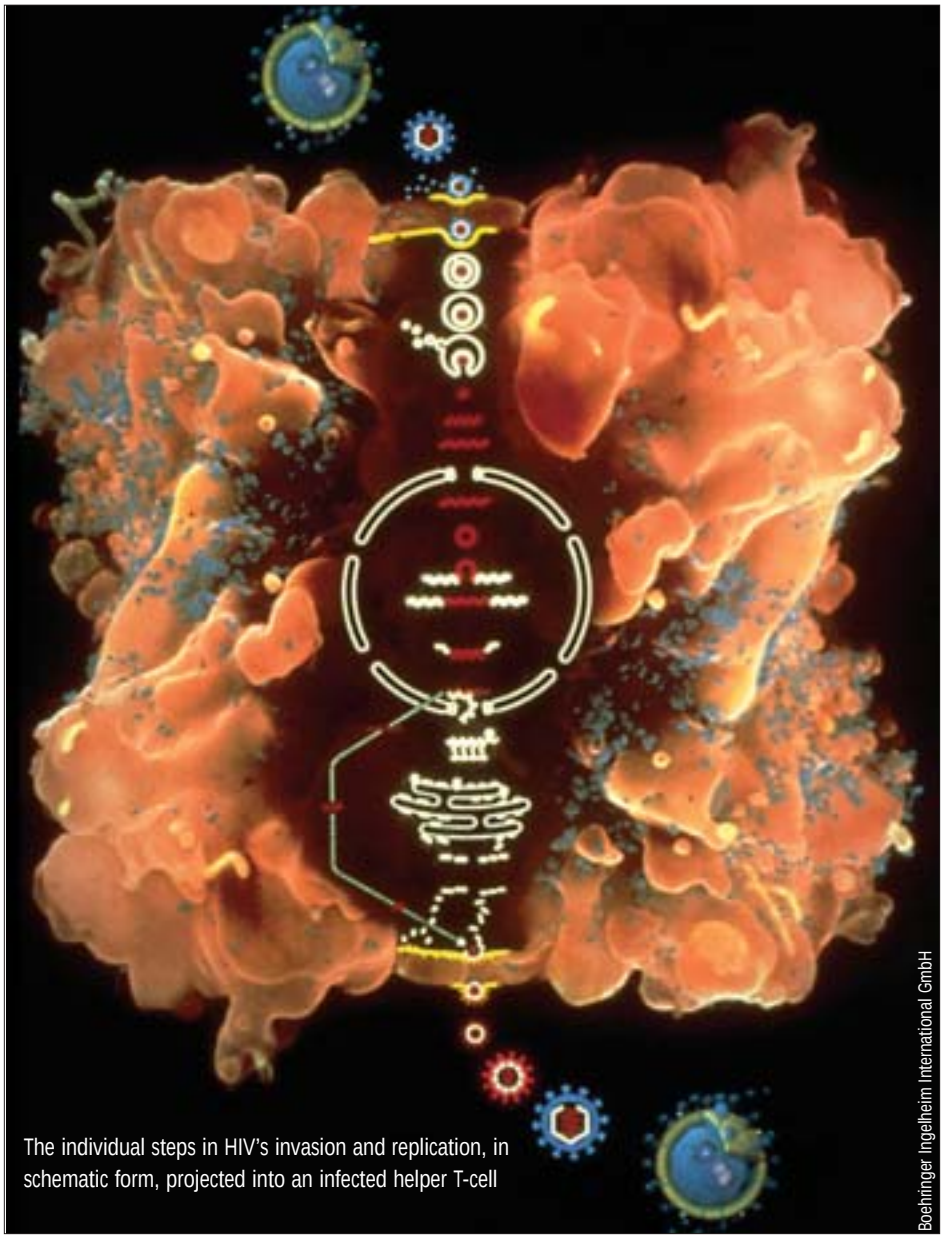
WHEN DOES AN HIV INFECTION BECOME AIDS?

On an average, most people who contract HIV develop AIDS within 8-10 years after they are first infected. Average adult life expectancy after an AIDS diagnosis ranges from 6-12 months in the developing world, and 1-2 years in the developed world. A small minority of people with HIV, perhaps one in 20, appears to remain free of AIDS for as long as 15 years.

Some infants born with HIV progress rapidly to AIDS, developing symptoms after four months, but others do not develop AIDS for eight years or longer.

CAN AIDS OCCUR WITHOUT HIV?

The existence of immunodeficiency was documented long before the onset of the HIV epidemic, but it was extremely rare, except in cancer patients receiving chemotherapy, transplant recipients receiving immunosuppressive therapy, or individuals born with rare inherited diseases. HIV infection is the most common



The individual steps in HIV's invasion and replication, in schematic form, projected into an infected helper T-cell

Boehringer Ingelheim International GmbH

cause of acquired immune deficiency.

HOW IS AIDS DIAGNOSED?

Internationally, the onset of AIDS is defined by the decrease in the number of CD4 white blood cells (critical in mounting immune responses) to 200 per cubic millimetre of blood. However, some researchers say that the average CD4 count in Indians is different from that in Caucasians—while Caucasians reach the "AIDS condition" at 200 cells/mm3 of blood, the equivalent immune deficiency for Indians occurs at 120 cells/ mm3 of blood.

In terms of symptoms, AIDS is diagnosed when a person who is HIV+ displays one or more of the AIDS-defining illnesses, which include:

- Candida (thrush/fungal infection) in the oesophagus, throat, or lungs;
- Invasive cervical cancer;
- Herpes simplex virus, which causes prolonged skin problems;
- HIV-related encephalopathy;
- Chronic intestinal diarrhoea;
- Kaposi's sarcoma;
- Certain lymphomas; and
- AIDS wasting syndrome.

Doctors usually suspect AIDS when patients manifest certain symptoms, suffer a series of infections, and respond poorly to the treatment of individual infections. As an example, tuberculosis (TB) on its own is almost always confined to the upper lungs. But in HIV patients, it frequently spreads elsewhere in the body.

CAN THE DEVELOPMENT OF AIDS BE STOPPED?

No, the progress from being HIV+ to AIDS is considered inevitable by doctors. However, the onset of clinical AIDS can be delayed by the use of anti-retroviral drugs.

WHAT DRUGS ARE USED TO TREAT HIV/AIDS?

Medicines used to battle HIV infection are known as anti-retroviral drugs (ARV) and treatment with them is known as anti-retroviral therapy (ART). The drugs broadly fall into four classes:

- NRTIs (nucleoside or nucleotide reverse transcriptase inhibitors);
- NNRTIs (non-nucleoside reverse transcriptase inhibitors);
- PIs (protease inhibitors); and
- Fusion inhibitors.

All four classes of medication have been designed to interfere with HIV's ability to reproduce inside the body. Each class of medication stops the virus at a different moment in its reproductive cycle. The current practice is to use a combination of the drugs, such as one NNRTI plus two NRTIs, or one PI plus two NRTIs, or one "boosted" PI plus two NRTIs, or three NRTIs.

HOW EFFECTIVE ARE THESE DRUGS?

No drug can get rid of an HIV

infection permanently. Rather, the drugs available aim to preserve and restore the immune system, maintain as low a viral load as possible, minimize side-effects and drug interactions, and prolong life and maintain quality of life.

The drugs also have side-effects—like most medication does—such as nausea, rashes, fever, fatigue, high cholesterol levels, insulin problems, liver damage, and anxiety.

HOW LONG MUST THESE DRUGS BE TAKEN?

ARV has to be continued for life. That is why the exact regime of treatment is a fairly complicated choice. HIV rapidly evolves mutants that are resistant to these drugs if they are taken in inappropriate doses or irregularly, or if they are discontinued. The resultant drug-resistant strain is then an even greater danger.

ARE ANTI-RETROVIRALS AVAILABLE IN INDIA?

Yes. Indeed, Indian pharmaceutical companies supply ARV drugs to many parts of the world, including Africa and South America. When these companies entered the market, they sold drugs at 2-5% of the prevailing international prices.

Free ARV medication is becoming available in a limited manner through the public health system. The Government of India is committed to expanding the reach of ARV. The price varies between Rs 5,000 and Rs 15,000 per year.

CAN DRUGS STOP THE INFECTION IMMEDIATELY AFTER EXPOSURE?

Post Exposure Prophylaxis (PEP) is generally available to doctors or nurses who could get infected while treating or operating on HIV patients. It should be started within 72 hours of suspected infection and is effective against HIV infection.

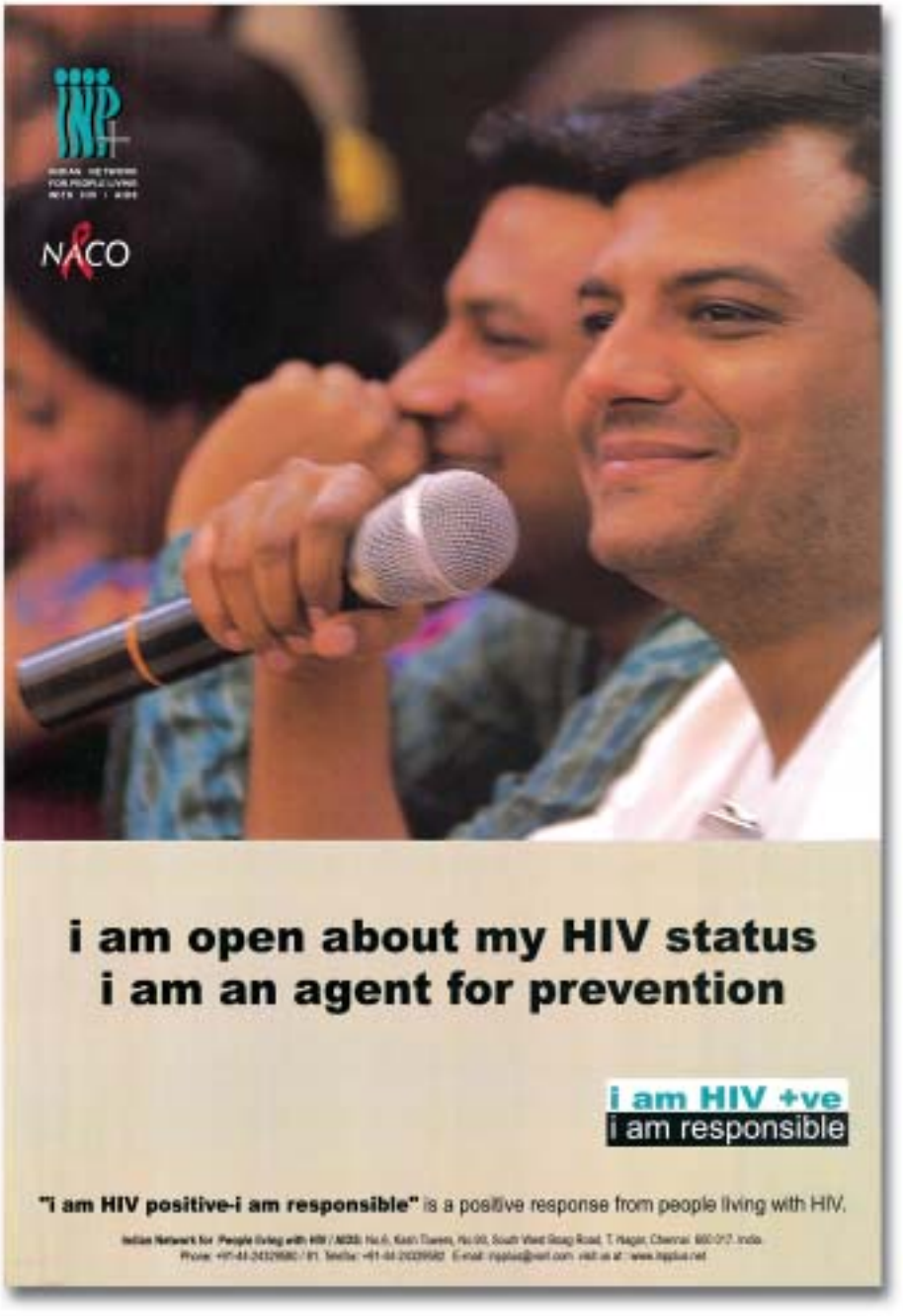
ARE THERE HIV/AIDS VACCINES?

Many hopes are pinned on the successful development of vaccines, both prophylactic to prevent HIV infection, and therapeutic to slow or halt the progressive damage to the immune system in infected people. But top scientists said in March 2005 (at the end of a global meeting on diseases control and research in Nairobi) that the world will have to wait another 15 years for an HIV vaccine.

Finding a vaccine against HIV is difficult. Scientists still do not know which parts of the body's immune response are important to mimic if they are to design a vaccine that will protect people against infection. A vaccine based on one strain of the virus may not protect people against other strains, and there are many different strains circulating worldwide.

ARE HIV/AIDS VACCINES BEING DEVELOPED IN INDIA?

No, but in February 2005, the Government of India, in collaboration with the International AIDS Vaccine Initiative (IAVI), began Phase I clinical trials on human subjects for the tgAAC09 vaccine developed in USA. A Phase I vaccine trial is the first stage of human testing, and the primary purpose is to evaluate safety. The trial will take roughly 15 months to complete and will enrol 30 volunteers, men and women, who are in good health and not infected with HIV. Human trials have already been carried out in USA, Europe, and Africa, but the mutation of the virus has hampered the discovery of a successful vaccine.


NACO
i am open about my HIV status
i am an agent for prevention
i am HIV +ve
i am responsible
"i am HIV positive-i am responsible" is a positive response from people living with HIV.

A SPIRALLING EPIDEMIC

IN the 10 seconds that it takes to read this paragraph, the HIV/AIDS epidemic would have claimed one more life somewhere in the world. Worldwide, 3.1 million people died of AIDS in 2004. Every sixth death (one every minute) is of a child below the age of 15.

Every six seconds, one more person is infected with HIV—this is 10 infections per minute.

At the end of 2004, there were 39.4 million people around the world living with HIV/AIDS, according to UNAIDS. Sub-Saharan Africa (44 countries, totalling 10% of the world's population) contributes almost two-thirds (64%) of this alarming figure, with 25.4 million infections and an adult prevalence rate of 7.4%.

About one-third of those living with HIV/AIDS in the world today are young—between 15 and 24 years old. At the end of 2004, 2.2 million children below the age of 15 years were living with HIV/AIDS.

The HIV/AIDS epidemic killed 3.1 million people globally in 2004, but the year also saw 4.9 million people newly infected by the virus. Around 640,000 of these new infections were children, over 90% of them infected through mother-to-child transmission (MTCT). Africa has almost 90% of the new child infections, but the numbers are rising just as frighteningly in Asia.

India: Cause for Concern?

There is only one country that has a larger number of HIV-infected people than India—South Africa, which had 5.3 million infected people at the end of 2003.

Though the prevalence rate in India (in percentage terms) is low, the sheer numbers are cause for concern.

In India, 5.134 million people were estimated to be living with HIV at the end of 2004. This is a prevalence rate of 0.91% among adults aged 15-49. More than 1,130,000 infections were added in 2002 and 2003. In contrast, a mere 28,000 new infections were added in 2004, according to the National AIDS Control Organization (NACO). There are many, including the executive director of the Global Fund To Fight AIDS, Tuberculosis and Malaria, Richard Feachem, who dispute these figures.

The cumulative number of AIDS cases reported to NACO till July 2005 is 111,608. In contrast, UNAIDS estimates that between 160,000 (low estimate) and 560,000 (high estimate) Indians died of AIDS in 2003 alone, but this figure is hotly disputed by NACO.

There is reason to believe that figures are grossly underreported because of factors such as the stigma associated with HIV/AIDS, reluctance to talk about sex or drug use, lack of knowledge, and uneven monitoring. AIDS deaths could go unreported because people die without access to medical aid or because their deaths are attributed to opportunistic infections instead.

There are various projections for the future. The National Intelligence Committee of USA believes there will be 20-25 million HIV+ people in India by 2010. The Government of India considers these figures alarmist.

Global Summary of the HIV/AIDS Epidemic, December 2004				
	Adults	Women	Children under 15 years	Total
Number of People Living with HIV in 2004	37.2 million	17.6 million	2.2 million	39.4 million
People Newly Infected with HIV in 2004	4.3 million		640,000	4.9 million
AIDS Deaths in 2004	2.6 million		510,000	3.1 million
Source: UNAIDS				

GEOGRAPHICAL SPREAD

Africa

The HIV/AIDS epidemic is at its peak in Southern Africa. Leaving aside Angola, each of the other eight countries in this region displays alarming adult prevalence rates: Swaziland (38.8% HIV prevalence), Botswana (37.3%), Lesotho (28.9%), Zimbabwe (24.6%), South Africa (21.5%), Namibia (21.3%), Zambia (16.5%), and Malawi (14.2%).

HIV prevalence here appears stable, but the reason for that is frightening: The number of new HIV infections in a year practically equals the number of AIDS-caused deaths.

The region displays several factors that are keeping the HIV epidemic going—poverty and social instability that result in family disruption, high levels of other sexually transmitted infections, low status of women, sexual violence, high mobility that is linked for the large part to migratory labour, and ineffective leadership during critical periods in the spread of the epidemic.

Asia

Some of the world's fastest growing epidemics are to be found in Asia—8.2 million infected people and half a million deaths in 2004.

China and India have a seemingly low HIV prevalence—0.1% and 0.9%, respectively. But these are also the world's two most populous countries, which means the epidemics here are serious enough. China alone will have 10 million infections by 2010 unless effective action is taken.

Inadequate monitoring and lack of awareness are spurring the epidemic in Indonesia, Cambodia, Myanmar, and Thailand. For example, in Indonesia, a UNAIDS study found that 88% of injecting drug users (IDUs) were using non-sterile equipment, but did not feel they were at high risk of HIV infection. In Cambodia, which has the highest prevalence figures in Asia of 3%, there is little effort to monitor IDUs and males who have sex with males.

In Central Asia, 80% of those infected with HIV are below the age of 30. In contrast, in North America and Western Europe, only 30% of infected people are under 30.

Europe and America

Estonia, Latvia, and Ukraine are the worst affected in Eastern Europe. Drug use and unsafe sex, separately, are the prime factors here. Sex between males is the primary mode of infection in this region. Poland is recording most of the new infections here.

Interestingly, in the UK, the recent rise in new HIV diagnoses is being partly attributed to increases in HIV testing—of the males who had sex with males diagnosed with the virus in 2002, about half had been

When a lion comes to the village, you don't make a small alarm. You make a very loud one. When I knew of AIDS, I said we must shout and shout and shout and shout.

— Yoweri Museveni
President, Uganda

Regionwise HIV/AIDS Statistics and Features, End of 2004

Region	Adults & Children Living with HIV/AIDS*	Adults & Children Newly Infected*	Adult Infection Rate (%)	Deaths of Adults & Children*
Sub-Saharan Africa	25.4	3.1	7.4	2.3
East Asia	1.1	0.29	0.1	0.051
South and South-East Asia	7.1	0.89	0.6	0.49
Oceania	0.035	0.005	0.2	0.0007
Eastern Europe & Central Asia	1.4	0.21	0.8	0.060
Western & Central Europe	0.61	0.021	0.3	0.0065
North Africa & Middle East	0.54	0.092	0.3	0.028
North America	1.0	0.044	0.6	0.016
Caribbean	0.44	0.053	2.3	0.036
Latin America	1.7	0.24	0.6	0.095
Global Total	39.4	4.9	1.1	3.1

Source: UNAIDS ** millions*

infected for more than six years.

A welcome trend is emerging in Western and Central Europe and North America. In these developed regions, the number of people living with HIV/AIDS is actually rising, not because of new infections, but because people here have access to anti-retroviral treatment and are living healthily longer than before.

African Americans, who form just 12% of USA's population, accounted for at least 25% of all AIDS cases in 2003; 54% of new HIV infections came from this group. African American women accounted for 72% of new HIV diagnoses in all American women.

The Caribbean is the second most HIV-affected region in the world, with 2.2 million infected people. AIDS is the leading cause of death here among those aged 15-49 years. In the Caribbean, Haiti is at most risk with 2% of its population infected with HIV. Though still concentrated among sex workers here, the epidemic is spreading in the general population, too.

India

Outside South Africa, India has the largest number of people living with HIV/AIDS—estimated to be 5.134 million in 2004. The first case of HIV in India was reported in Chennai, Tamil Nadu, in 1986.

India is one of the few countries that initiated HIV-prevention activities in the very early stages of the epidemic and has maintained its commitment to prevention efforts. Despite these efforts, however, HIV knowledge is still scant and incomplete in

Rural vs Urban: Distribution of HIV+ Population in India

Residence	Male	Female	Infected Population (Lakhs)	Percentage
Urban	13.29	7.98	21.27	41.43
Rural	18.03	12.04	30.07	58.57
Total	31.32	20.02	51.34	100.00

Source: NACO; Figures for 2004

India. India's socioeconomic status, traditional social norms, cultural myths on sex and sexuality, large-scale migration, and its huge population of marginalized people make it vulnerable to the HIV epidemic.

The pattern of HIV infection in India has the following characteristics:

- HIV is affecting mainly young people in the sexually active age group. The age group of 15-44 years has 87.7% of the HIV infections in India;
- The predominant mode of transmission of HIV infection is through sexual contact (85.7%), followed by injecting drug use (2.2%), blood transfusion and blood product infusion (2.6%), and perinatal transmission (2.7%);
- Women are estimated to account for about 39% of HIV infections; and
- The predominant opportunistic infection among AIDS patients is tuberculosis, indicating a potential future high spread of the HIV-TB co-infection.

AIDS Cases in India as Reported to NACO

Total Number of AIDS cases: 111,608

STATE	AIDS CASES	
Andhra Pradesh	12,349	11.1%
Gujarat	5,636	5.05%
Karnataka	2,896	2.6%
Maharashtra + Mumbai	21,231	19.02%
Manipur	2,866	2.56%
Tamil Nadu	52,036	46.6%

Source: NACO; Figures till July 2005

The Indian states with the highest HIV/AIDS prevalence are Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Nagaland, and Manipur.

Pushed by injecting drug use, the epidemic has been in full swing in Manipur for more than a decade and now has a firm presence in the wider population as well. Interpreting data from antenatal clinics in the cities of Imphal and Churachandpur, HIV prevalence has been found to have risen from below 1% to over 5% in 2003.

Injecting drug use is playing a bigger role than previously thought. In Chennai, Tamil Nadu, for example, 26% of drug injectors were already infected with HIV when a sentinel site was established there in 2000; by 2003, 64% were infected.

In most Indian cities where injecting drug users have been surveyed, a quarter of them said they

Risk/Transmission Categories for AIDS Cases Reported to NACO

Risk/Transmission Categories

	NO. OF CASES	PERCENTAGE
Sexual Intercourse	95,941	85.96
Perinatal Transmission	4,059	3.64
Blood and Blood Products	2,231	2.00
Injecting Drug Users	2,672	2.39
Others (Not Specified)	6,705	6.01
Total	111,608	100.00

Source: NACO; Figures till July 2005

lived with a wife or regular sex partner; in Chennai, 46% said so, which probably explains why Chennai also has one of the highest HIV rates among pregnant women in India. In Andhra Pradesh, Karnataka, Maharashtra, and Nagaland, HIV prevalence has crossed the 1% mark among pregnant women.

The HIV/AIDS epidemics in Maharashtra, Tamil Nadu, and Andhra Pradesh are driven by commercial sex. Sentinel surveillance finds no significant drop in HIV prevalence among the sex workers in Mumbai despite decades of safer-sex programmes. HIV prevalence among sex workers in Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu is more than 50%.

HIV Prevalence among Antenatal Clinic Attendees

Antenatal clinic attendees are considered to be representative of the general population

STATE	%
Andhra Pradesh	2.25
Goa	1.13
Karnataka	1.25
Maharashtra	1.25
Mumbai	1.12
Manipur	1.50
Mizoram	1.25
Nagaland	1.43

Source: NACO; Figures for 2004

In Gujarat, Pondicherry, and Goa, HIV prevalence among groups such as STD clinic attendees and intravenous drug users shows a rate of more than 5%.

India does boast of some significant successes: In Tamil Nadu, after several prevention programmes, the number of truck drivers reporting unprotected sex with a sex worker has fallen from 14% in 1996 to 2% in 2003.

Prevention and Control Measures

The second phase of the National AIDS Control Programme (NACP-II) has been established through the National AIDS Control Organization (NACO), the Ministry of Health and Family Welfare, and State AIDS Control Societies in every state.

In 2004, India introduced free anti-retroviral treatment in government hospitals. The programme initially began in the six high-prevalence states. In addition, India is deploying evidence-based planning of all interventions for HIV prevention, care, treatment, and support, by mapping the sections of the population that are the most vulnerable to HIV infection.

Consultations are currently underway for the launch of NACP-III, the third phase of the National AIDS Control Programme, scheduled to begin in 2006.

LONG-TERM IMPACT

HIV is a lentivirus—it has a slow incubation period—which means infected persons are active (and thus, infectious to others) for many years. The true impact of the epidemic is often felt years later.

Since HIV is mainly transmitted sexually, it affects those who are in the prime of their lives—those who are the most socially and economically productive. HIV changes the ratio of dependents to producers.

The HIV epidemic is wiping out development gains, decreasing life expectancy, increasing child mortality, orphaning millions, setting back the situation of women and children, and threatening to undermine national

security in highly affected societies.

ECONOMIC IMPACT

AIDS constitutes a grave threat to development by the mere fact that it kills people in the prime of their working and parenting lives. According to a World Bank calculation, AIDS costs 24 African countries 0.5-1.2% of per capita growth each year. In some countries, conservative estimates indicate that the number of people living in poverty has increased by 5% as a result of the epidemic. The epidemic is causing these countries to slide back.

Governments are suffering a drain on skills, reduced revenues, lower return on social investment, and reduced national security, while facing vast expenses on health and orphan care. Businesses face higher costs in training, insurance, benefits, absenteeism, and illness. Reports are common of healthcare costs rising five or 10 times within a few years. HIV may cut productivity growth by as much as 50% in the worst-hit countries.

SOCIAL IMPACT

HIV overtaxes social systems and impedes the development that enables poor people (especially children) to escape poverty. Life expectancy has plummeted by 20 years in some countries and the number of orphans is expected to more than double by 2010. This will pose unprecedented social welfare demands.

Women in general, and girls in particular, are more vulnerable to HIV/AIDS and are disproportionately affected by the epidemic. Families remove girls from school to care for sick relatives or assume family responsibilities, thereby jeopardizing gains in female health, nutrition, and education. Girls who have not completed their schooling are less likely to obtain the earning power to increase their economic independence, and more likely to resort to transactional sex in order to survive.

Estimates of HIV in India from 1998 to 2004

1998	1999	2000	2001	2002	2003	2004
3.5 million	3.7 million	3.86 million	3.97 million	4.58 million	5.106 million	5.134 million

Source: NACO

RECENT NEWS STORIES ON HIV/AIDS

THERE is a constant flow of news regarding HIV/AIDS in the media and on specialist websites. Statistics, controversies, positive stories, worrying developments, heart-rending reports—thus far, the last year has seen all of them. Here's a brief recapitulation of the more important ones.

SON DIED OF AIDS-RELATED DISEASE: MANDELA

Former president Nelson Mandela of South Africa announced that his eldest son had died of an AIDS-related disease, making a highly unusual disclosure. Mandela's son, Makgatho, was 54 and died in January 2005. Mandela said that he was speaking out to try to reduce the stigma that has limited public discussion and efforts against the syndrome.

"For some time I have been saying, let us give publicity to AIDS and not hide it," Mandela said. "It is the only way to make it appear like a normal illness. To come out and say someone has died of HIV, then people will stop regarding it as an illness reserved for people who go to hell and not heaven."

ROW OVER INDIA'S HIV FIGURES

Richard Feachem, executive director of the Global Fund To Fight AIDS, Tuberculosis and Malaria, said in April 2005 that the HIV/AIDS epidemic is out of control in India, and "there is nothing happening in India today that is big or serious enough to prevent it". Feachem estimated that India now has more HIV+ people than even South Africa, which has the largest number of HIV+ people in the world.

Nelson Mandela

However, the Indian Government dismissed Feachem's claim as "nonsense". National AIDS Control Organization director-general S Y Quraishi said, "We are aware of the gravity of the situation and we have programmes to deal with it. Our (AIDS) surveillance systems are certified by the World Health Organization, UN agency UNAIDS and the Indian Council of Medical Research (ICMR). We stand by our figure of 5.1 million (infections)."

FREE ART, BUT NOT FREELY AVAILABLE

In April 2004, the Government of India began distributing free anti-retroviral drugs, first in eight anti-retroviral therapy (ART) units in government medical colleges. The number of ART centres was expanded to 25 (in 13 states), and by July 2005, the health ministry said more than 10,000 PLWHA were getting free drugs. Another 9,000 PLWHA were getting free ART from other government centres such as defence facilities or the Railways.

Soldiers of the Indian Army

The Government says it will provide free ART to 1,00,000 persons by 2007. It says 100 free ART centres will be functional by the end of 2005.

However, the project ran into trouble quite early with the number of patients turning up for the treatment proving to be much higher than anticipated. Numerous complaints of shortfall of drugs were voiced. Estimates of the number of patients had to be revised in several centres.

ARMED FORCES HIT BY HIV/AIDS

HIV in the armed forces came into the public eye in April 2005 when Lt Gen. Bhopinder Singh, director-general of Assam Rifles, said more soldiers were killed by HIV/AIDS than bullets in India's insurgency-hit North East. Singh said HIV infections among Indian troops were assuming "serious dimensions".

Most of the HIV+ cases in the armed forces have been reported from Mumbai, Chennai, and the North East.

India later signed a pact with the United Nations to combat HIV infections among about 1.3 million personnel in the Indian Army and 535,000 paramilitary soldiers.

POOR FUND UTILIZATION BY NACO

India's Comptroller and Auditor General (CAG) took the National AIDS Control Organization (NACO) to task for

poor utilization of funds meant for containing the HIV epidemic.

In a report presented to Parliament in July 2005, the CAG revealed that NACO was able to utilize only 46% of the more than $300 million made available to it for the second phase of the National AIDS Control Programme (NACP-II), which is scheduled to end in October 2005.

The story of how 46% of the available funds was actually utilized is grimmer with the CAG unearthing serious deficiencies, including misuse of funds in key targeted interventions such as promotion of condoms, improving clinics treating sexually transmitted diseases (STDs), behavioural change communication, and baseline studies.

15-YEAR WAIT FOR VACCINE

The world will have to wait for another 15 years for an AIDS vaccine, top scientists said in March 2005, at the end of a global meeting on diseases control and research in Nairobi.

The manufacture of vaccines for tropical diseases such as tuberculosis and malaria would also take between five and 15 years, scientists attending the meeting were quoted as saying. They attributed the long wait to complex scientific studies linked to the diseases and lack of funding, said the report.

INDIA LAUNCHES HUMAN TRIAL OF HIV/AIDS VACCINE

India launched its first human clinical trials of a vaccine to prevent HIV/AIDS in February 2005.

The "investigational" vaccine was being tested on 30 volunteers in a first phase of the trial, health minister Anbumani Ramadoss said. The trial is being conducted at the National AIDS Research Institute, Pune.

Trials for a second AIDS vaccine will begin at the Tuberculosis Research Centre (TRC) in Chennai by the end of the year.

More than 20 potential AIDS vaccines have been developed worldwide, but the only one to reach large-scale testing failed in clinical trials in 2003 in North America and Thailand.

'INDIANS VULNERABLE TO HIV/AIDS'

A study in April 2005 suggested that Indians infected with HIV are more likely to contract AIDS than people in the West. Scientists at India's premier medical school, the All India Institute of Medical Sciences (AIIMS), carried out the study on 200 HIV+ people and 2,000 healthy people over two years.

The scientists said that Indians have lower immunity to the virus because they have genes that hasten the progress of the infection. Protective genes are low among Indians, while the harmful genes linked to rapid progression from HIV infection to AIDS are more common, according to the study.

INDIANS HAVE DIFFERENT AVERAGE CD4 CELL COUNT

Different studies in 2005 said that Indians have lower CD4 cell counts than people in the West. Separate studies on South Indians and North Indians were quoted to show that Indians have an average CD4 cell count of about 800 cells/mm3 as opposed to just over 1,000 for North Americans. The average count for Chinese persons was stated to be 785 cells/mm3. CD4 cells are important elements of the immune system and the fall in their numbers is an important indicator of the onset of AIDS.

Look, it's just from a rubber tree like a tennis ball. If you're embarrassed by a condom, you must be more embarrassed by a tennis ball. There's more rubber in it. We gave them out all over, and said, "Look, the condom is clean if your mind is not dirty, so please take one."

— SENATOR MECHAI VIRAVAIDYA *, 'Condom King' and founder and chairman of the Population and Community Development Association, Thailand*

Some scientists suggested it would be appropriate to redefine the US Centers for Disease Control and Prevention (CDC) categories of HIV disease severity for different ethnic groups. For instance, CDC uses a CD4 count of 200 to define the onset of AIDS (when AIDS-defining conditions would be expected to develop), but some scientists said the corresponding level for Indians should be 120.

15% PLWHA RESISTANT TO DRUGS

Tests conducted on a small random group of HIV+ people in Chennai in March 2005 revealed that nearly 15% of them were already resistant to drugs.

A sample size of 50 persons was chosen in Chennai by Dr P Balakrishnan to conduct the study on drug resistance.

PATENT BILL THREATENS ARV PRICES

In March 2005, India's Parliament passed a bill that would change the country's patent laws to prohibit the domestic production of low-cost, generic versions of patented medicines, including anti-retroviral drugs (ARVs). India's generic drug industry has made less-expensive medications available in India and abroad for more than 30 years. Since 1970, India has granted "process patents" rather than the usual "product patents" that all Western

Stack of condoms in a supermarket

countries grant. This allowed drug companies in India to produce generic versions of medications patented in other countries as long as they used a different manufacturing process.

UGANDA APPEALS FOR INDIAN ARVS

Uganda, which has thousands of HIV/AIDS-affected people, appealed to the international community to intervene after India brought in legislation that Kampala fears will prevent access to low-cost HIV drugs.

Over 80% of the anti-retroviral drugs (ARVs) consumed by Ugandans were manufactured by Indian companies, Uganda's health services director Francis Omaswa said.

About 45,000 HIV-infected Ugandans were currently on ARVs with the number projected to reach 60,000 by the end of the year, Omaswa said. Though some other countries also produced ARVs, a shortfall from India would cause an immediate drug shortage, he added.

ZAMBIA ANNOUNCES FREE ARV DRUGS

Zambia has procured enough anti-retroviral drugs (ARVs) to be given free to 1,00,000 people living with HIV/AIDS by December 2005, local media reported in August 2005.

Ministry of Health spokesperson Victor Mukonka was quoted as saying that the ministry has directed all health institutions in Zambia to put persons living with HIV/AIDS on free ARVs.

BRAZIL SNUBS USA ON MORALITY

In May 2005, Brazil became the first country to reject AIDS funding from USA, citing its unwillingness to play by Washington's ideological rules.

Brazil rejected $40 million in US funds for fighting AIDS because of demands that it condemn prostitution. The move is seen by some observers as a rejection of Washington's head-in-the-sand linkage of morality and foreign aid.

Acting in accordance with a 2003 federal law, the US Congress had demanded that Brazil publicly condemn prostitution before accepting the funds from the US Agency for International Development, or USAID. Prostitution is a legal industry in Brazil and a key civic player in fighting the spread of HIV/AIDS.

PROSECUTIONS FOR HIV TRANSMISSION ON THE RISE IN EUROPE

A report prepared by The Global Network of People Living with HIV/AIDS Europe (GNP+ Europe) and the Terrence Higgins Trust (THT) showed that the actual or potential transmission of HIV can constitute a criminal offence in 36 of the 45 European countries surveyed.

At least one person has been prosecuted in 21 of these countries, and there have been at least 130 convictions all over Europe. Notably, Austria, Sweden, and Switzerland are responsible for more than 60% of the total convictions and have each prosecuted more than 30 people. At the other end of the scale, either HIV exposure or transmission does not appear to be criminal offences in Albania, Bulgaria, Luxembourg, Slovenia, and the Republic of Macedonia.

CIRCUMCISION STUDY ANGERS VHP

A study published in January 2005 reported that uncircumcised men have more than twice the risk of acquiring HIV than do circumcised

Richard Feachem

men. Richard Feachem, executive director of the Global Fund To Fight AIDS, Tuberculosis and Malaria, said in April that he expected the epidemic to grow faster among India's majority Hindu population than among Muslims because of the custom of male circumcision in the latter community, causing outrage in the Vishwa Hindu Parishad (VHP).

''This is obnoxious. Has there been any study done on the spread of HIV/AIDS within the different religious communities in India? Anyway, we are not going to tolerate such remarks made against Hindus,'' said the furious VHP leader, B P Singhal.

NACO PROMOTES CONDOMS

Ending a phase of fighting shy of promoting condoms because of cultural sensitivities, the National AIDS Control Organization (NACO) launched a condom called Dipper for the nation's trucking community. The name was inspired by the request for dimmed headlights painted on the back of every truck in the country, "Use Dipper at Night", which NACO's director-general, S Y Quraishi, hopes will provide plenty of free advertising. Quraishi was appointed to NACO in September 2004.

A series of advertisements promoting condom use were also seen on television in 2005.

HIV 'SUPER STRAIN'

A "super strain" of HIV was claimed to have infected a New York man in February 2005. The 46-year-old patient acknowledged he had had anonymous unprotected sex with hundreds of men, often while using crystal meth, a recreational drug.

The alarming feature of this particular case of infection was the rapid progression of AIDS in the patient—much faster than in other HIV+ people—and the fact that the virus exhibited mutations that were resistant to 19 of the 20 drugs commonly used to treat HIV. Even more unusual was the swarm of virus infecting the patient.

However, other researchers have found no evidence to support the existence of the "superbug". They see the case as rare and worthy of investigation, but not cause for a public warning. They believe the rapid progression was more likely the result of factors unique to the patient's genetics and health, not the virus.

MANDATORY DISCLOSURE OF HIV STATUS

Singapore, facing a rise in AIDS cases, made it mandatory in July 2005 for spouses of HIV+ people to be

Promoting condoms in Uganda

informed of their partner's illness.

The Health Ministry said patient confidentiality had to be balanced against the duty to protect spouses from being infected.

The ministry has also considered introducing a series of legislative measures to halt the spread of the disease, including making it compulsory for pregnant women to be screened for HIV/AIDS, having HIV testing for couples about to marry and criminalizing the act of spreading the HIV virus—with or without intent.

USING MATRIMONIALS FOR HIV/AIDS AWARENESS

Some matrimonial advertisements have started carrying information on the HIV/AIDS status of prospective partners. This is a welcome development for raising awareness about voluntary pre-marital testing for HIV.

CONSULTATIONS BEGIN FOR NACP-III

Preparations for the World Bank-supported National AIDS Control Programme Phase-III (NACP-III) began in July 2005 with consultations on its design and policy dialogues with activists. NACP-III will begin in April 2006.

LIFE INSURANCE FOR DUTCH PLWHA

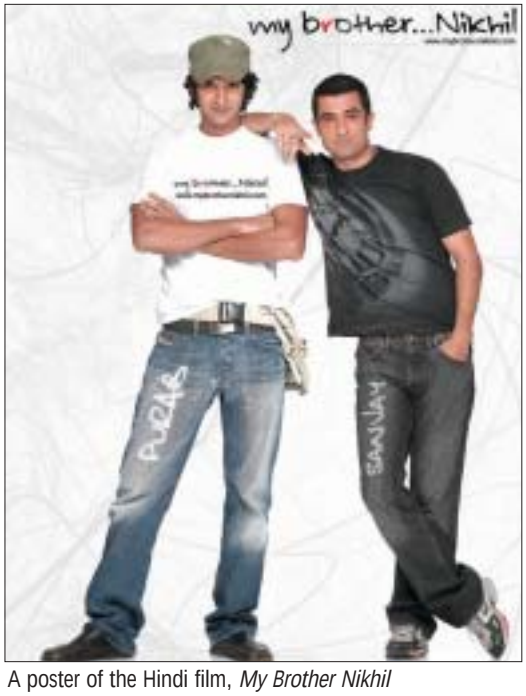
Several insurance companies in the Netherlands agreed in March 2005 to start offering life-insurance policies to PLWHA under certain conditions—they should have responded positively to medical treatment, have had no further medical complications, and never have used drugs intravenously. The policies will benefit 2,500 of the estimated 20,000 HIV+ people living in the Netherlands, the Dutch Association of Insurers said.

The Association said it had conducted a formal study and decided that the risk was comparable to that associated with people suffering from diabetes or heart problems.

Both Britain and France offer life-insurance products to PLWHA, but the premiums are very high. In the Netherlands, however, the premiums are expected to be more affordable. In USA, people living with HIV/AIDS cannot be denied group life-insurance policies through employers or associations, but they are routinely denied individual policies.

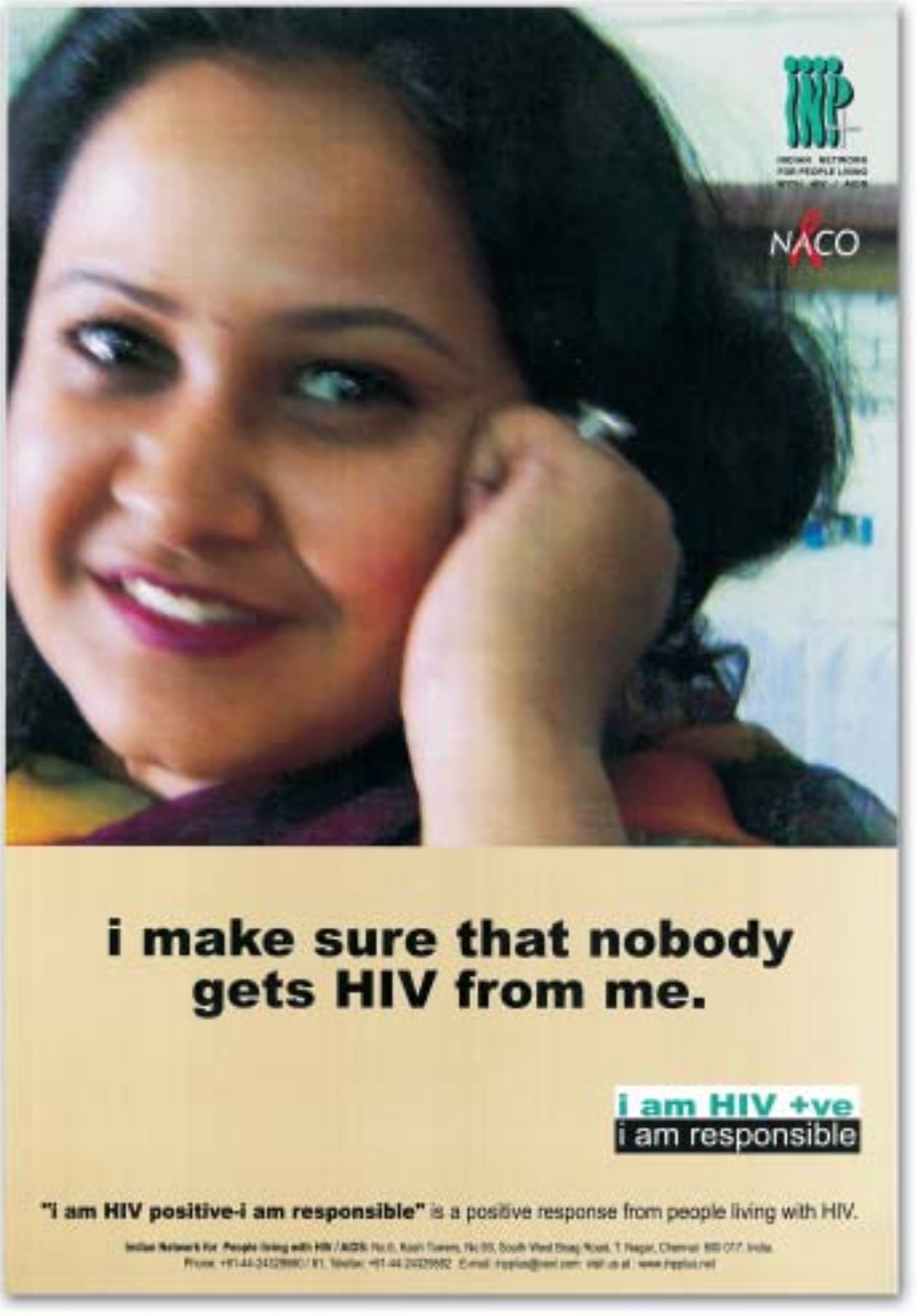
AIDS IN THE MOVIES

Bollywood, the world's most prolific film industry, finally seemed to have woken up to AIDS.



A poster of the Hindi film, *My Brother Nikhil*

First came *Phir Milenge* in 2004, featuring Shilpa Shetty and Salman Khan as PLWHA. It was followed by *My Brother Nikhil*, in which Sanjay Suri played an HIV+ person. Both films highlighted the stigma and discrimination faced by PLWHA.


NACO
i make sure that nobody
gets HIV from me.
i am HIV +ve
i am responsible
"i am HIV positive-i am responsible" is a positive response from people living with HIV.

THE GOVERNANCE FACTOR

WHY GOVERNANCE

Does governance—good or bad—have anything to do with the HIV/AIDS epidemic? At first, it may seem far-fetched to imply a relationship between the two. But experts and political scientists say the two are intricately related. Simply put, they say that good governance is invaluable in controlling the spread of HIV/AIDS; conversely, bad governance allows infection and death rates to spiral out of control.

Donor nations and organizations are increasingly linking good governance to the release of funds for combating HIV. Partly, this can be viewed as an effort to ensure proper utilization of funds and to have them benefit the cause and persons for which they are intended. But beyond that, the principles of good governance are an important tool with which to analyse political and social processes.

THE LINK BETWEEN GOVERNANCE AND HIV/AIDS

The Commission on Global Governance (1995) described governance as "...the sum of the many ways individuals and institutions, public or private, manage their common affairs". Good governance is then synonymous with good management of common affairs.

Good governance is important because of the widespread devastation that HIV/AIDS is capable of causing. A badly managed epidemic can devastate societies, depress growth, and dramatically lower life expectancy. Many African countries have been pinpointed as examples of bad governance. The other side of the coin is that countries such as Uganda and Thailand have demonstrated that the tide can be stemmed or turned with strategic vision and purposeful action.

A UNDP official, Lee-Nah Hsu, proposed the following "winning formula":

Development + Good Governance System = Low and Stable HIV Prevalence

It's not difficult to find examples to validate this hypothesis, even though it doesn't take into account social and cultural differences.

A government, by addressing the income and economic development aspects of its citizens' lives, is dealing with background HIV vulnerabilities that push the citizens to take risks which they would not have taken if the environment had been more propitious for their livelihood.

For instance, rural migrant workers, whose skills are farm based, may have little choice but to take up sex work after they arrive in a city. If alternative employment or skills training is provided to them, they need not come to the city at all. Providing this employment or training would reduce the workers' vulnerability to HIV/AIDS and would constitute good governance.

WHAT IS GOOD GOVERNANCE?

The UNDP says good governance is "...participatory, transparent and accountable. It is also effective and equitable.

In many places, there are compulsory medical checkups. Or when the entire staff goes for regular medical checkups, they conduct HIV tests without their consent. An employee cannot be dismissed at the whim and fancy of the management. The law requires disciplinary proceedings. So, they make up false charges.

— JAYNA KOTHARI
a lawyer with the Alternative Law Forum in Bangalore

And it promotes the rule of law. Good governance ensures that political, social, and economic priorities are based on broad consensus in society and that the voices of the poorest and the most vulnerable are heard in decision-making over the allocation of development resources."

Good governance goes beyond just good government, for it connotes a good understanding by the citizens of all the functions of the government and their involvement in the management of its institutions in ways that are clear, fair, and consistent, and promote human rights and well-being. Good governance applies at all levels of society.

On the other hand, weak governance almost always projects the image of corruption. Corruption thrives on the absence of transparency and accountability. In turn, it hampers the other elements of good governance—rule of law, equity, responsiveness, effectiveness, and vision.

THE ELEMENTS OF GOOD GOVERNANCE

Participation: All men and women should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their interests. Such participation is built on freedom of association and speech, as well as the capacities to participate constructively.

From the 'Begin a Dialog' ad campaign to promote the Compass Project's counselling service in San Francisco

RULE OF LAW: Legal frameworks should be fair and enforced impartially, particularly the laws on human rights.

TRANSPARENCY: Transparency is built on the free flow of information. Processes and institutions are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.

RESPONSIVENESS: Institutions and processes try to serve all stakeholders.

CONSENSUS ORIENTATION: Good governance mediates differing interests to reach a broad consensus on what is in the best interest of the group and, where possible, on policies and procedures.

EQUITY: All men and women have opportunities to improve or maintain their well-being.

EFFECTIVENESS AND EFFICIENCY: Processes and institutions produce results that meet needs, while making the best use of resources.

ACCOUNTABILITY: Decision makers in government, the private sector, and civil society organizations are accountable to the public as well as to institutional stakeholders.

This accountability differs, depending on the organization and whether the decision is internal or external to the organization.

STRATEGIC VISION: Leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding

of the historical, cultural, and social complexities in which that perspective is grounded.

GOOD GOVERNANCE IN ACTION

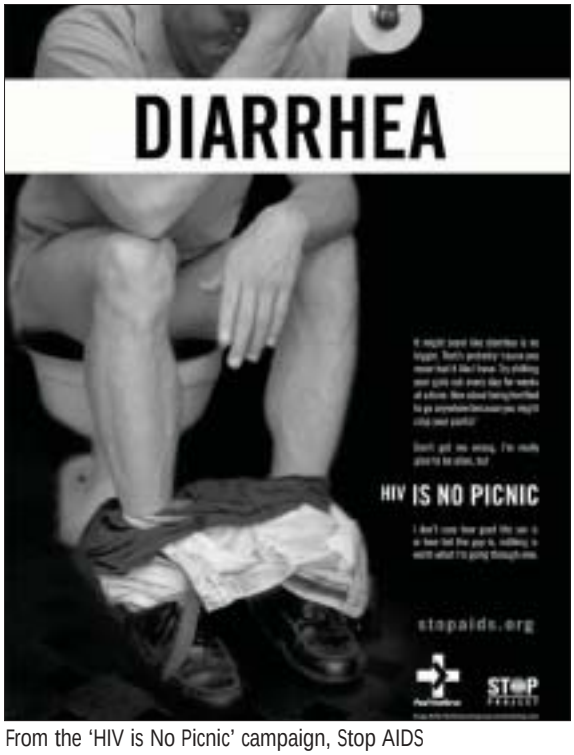
Some countries have incorporated good governance measures to create effective programmes that have been successful in stemming the spread of HIV/AIDS. Some of those that are repeatedly mentioned are Uganda, Thailand, and Senegal. In each of these countries, national HIV/AIDS programmes share a package of common features that are universally regarded as best practices:

- Strong political commitment at the highest level to dealing with the epidemic (this ensures policies and funding to address the epidemic);
- Multi-sector approaches to prevention and care and, at the government level, involvement by multiple ministries;
- Multi-level responses (at the national, provincial, district, and community levels);
- Effective monitoring of the epidemic and risk behaviours, and dissemination of the findings both to improve policies and programmes and to sustain awareness;
- A combination of efforts aimed at the general population and focused on groups at high risk, at the same time;
- Implementation on a large scale; and
- Integrated prevention and care.

SUCCESS STORY: UGANDA

One of the poorest countries in the world, Uganda is also one of the most severely affected by the HIV/AIDS epidemic. HIV prevalence among adults here is about 8%. Uganda was lucky in that its government and its people recognized the epidemic fairly early, because of which prevention efforts, including a national budget for the HIV/AIDS programme, were started on a national level.

Uganda adopted a multi-sectoral approach. The Uganda AIDS Commission was set up in the President's office in 1986, and HIV/AIDS control programmes were established in several government



From the 'HIV is No Picnic' campaign, Stop AIDS Project, San Francisco

ministries, including the Ministry of Health. Persons at different levels of society, such as political, community, and religious leaders, were involved. The Islamic Medical Association of Uganda has supported community education on HIV/AIDS throughout the country, including the distribution of condoms. Radio messages on HIV/AIDS were broadcast widely. Condom social marketing services, backed by USAID, were implemented countrywide. HIV voluntary counselling and testing were made avail-

able extensively and outside the formal healthcare service.

From 1989, the epidemic was tracked at six sites in major cities. By the mid-1990s, all these urban sentinel sites showed a significant decline in HIV infection. Prevalence among pregnant women aged 15-19 dropped from 22% in 1990 to 10% in 1996, after reaching a peak of 28% in 1991.

In 1989 and 1995, Uganda conducted two large population-based surveys (in the urban areas of Kampala and Jinja), which permit comparisons in the status of HIV infection in the country. The findings were as follows:

- The proportion of 15-year-old girls and boys reporting they had never had sex rose from 20% to 50%; and
- The number of men, across age groups, who said they had ever used a condom rose from 15% to 55%; the number of women rose from 6% to 39%.

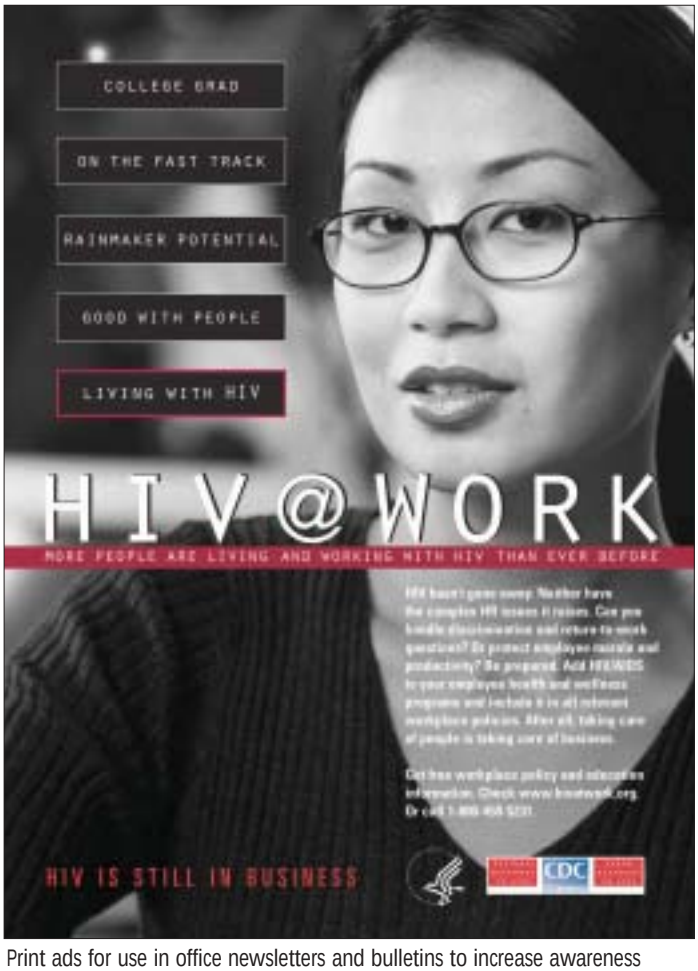
However, where Uganda is still lagging behind is in its rural areas, where the number of new infections is still high, even among the younger age groups. Considering that more than 86% of Uganda's 21-million population lives in rural areas, this is where Uganda needs to look next on an urgent basis.

SUCCESS STORY: THAILAND

Behavioural changes have reduced the annual number of new HIV infections in Thailand from 143,000 in 1991 to 29,000 in 2000. HIV prevalence among adults is about 1.9% here.

It was only in 1988 that the rapid growth of HIV infections among injecting drug users alerted the Thai government to the emerging problem. In 1991, an intensive and extensive prevention programme was put into place. Some of the guiding principles for the programme's implementation were:

- Focusing on populations with high-risk behaviour, such as sex workers and injecting drug users, is important, but the general population and young people are also critical;
- It is necessary to reach the population both extensively (on a broad level) and intensively (through many channels at the same time);
- Knowledge and awareness are important, but not sufficient; life-skills training (decision-making and negotiation, for example), condom promotion, and



Print ads for use in office newsletters and bulletins to increase awareness

long-term approaches such as changing social norms are also necessary; and

- Socioeconomic interventions are necessary to reduce vulnerability to HIV infection, as, for example, by increasing the opportunity for girls to continue their schooling and to receive vocational training so that they are less likely to become sex workers.

THE PROGRAMME INCLUDED SEVERAL ELEMENTS:

- The Prime Minister chaired the National AIDS Programme, his office actively participated in policy discussion, led the public education effort, and monitored the programme;
- The National AIDS Plan was integrated into the five-year National Development Plan;
- The government HIV/AIDS budget increased drastically;
- Each key ministry had its own HIV/AIDS plan and budget;
- Provincial governors led the HIV/AIDS programme in their respective provinces; and
- The business community, PLWHA, religious leaders, and other community leaders became very involved in contributing to policy dialogue, resource mobilization, and local implementation.

One of the most striking effects was in the number of visits to sex workers, the behaviour most closely associated with HIV infection in Thai studies. The proportion of urban men aged 20-24 who visited sex workers fell to 17% in 1993 from over 35% in 1990; that of urban men aged 25-29 dropped from 19% to 9%. The 1997 survey found that consistent condom use among sex workers increased from over 50% in 1990 to almost 90% in 1996.

GIPA: A Model for Participation

GIPA, or Greater Involvement of PLWHA, recognizes the principle that efficient control of HIV/AIDS cannot be achieved without the meaningful involvement of PLWHA. After all, it is the PLWHA who are experiencing first-hand the full ramifications of HIV infection.

The need for a greater involvement of PLWHA in HIV/AIDS control and information programmes was first voiced publicly in 1983. However, it was only at the 1994 Paris AIDS Summit that the acronym, GIPA, came into being. Since then, the principles have been adopted by UNAIDS and find prominent place in all international declarations relating to HIV/AIDS.

In India, UNDP undertook a pilot GIPA project in cooperation with the New Delhi NGO, Sahara, in 2001. The National AIDS Control Organization (NACO) commenced a partnership with the Indian Network of People Living with HIV/AIDS (INP+) in 2003 and INP+ was given the responsibility for finalizing the first national strategy for GIPA.

PLWHA are taking up a larger role in building networks, voluntary counselling and testing, and in facilitating the rollout of anti-retroviral therapy.

What are the GIPA Principles?

- To support the greater involvement of PLWHA with the aim of stimulating a supportive political, legal, and social environment;
- To involve PLWHA fully in decision-making, formulation, and implementation of public policies;
- To protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS, through legal and social environments;
- To make available necessary resources to better combat the pandemic, including adequate support for PLWHA, NGOs, and CBOs working with vulnerable and marginalized populations; and
- To strengthen national and international mechanisms connected to human rights and ethics related to HIV/AIDS.

INP+
NACO
i am positive...
you are O.K.
i am +ve
i am responsible
"i am positive-i am responsible" is a positive response from people living with HIV.

MAPPING THE MEDIA

HIV/AIDS has definitely arrived on the Indian media map. Though few quantitative or qualitative surveys have been conducted on the Indian news media's coverage of the epidemic, there is agreement that the amount of coverage has grown over the years. HIV/AIDS-related stories in newspapers and magazines, and on television, are frequent, and reach a peak during high-profile events. Non-news media—entertainment television, films, advertising, and websites—have also begun to play an important role.

However, the view persists that HIV/AIDS coverage (especially in the news media) leaves a lot to be desired. Adjectives such as inadequate, ill-informed, insensitive, sensationalist, stigmatizing, and unethical continue to be applied to media coverage.

This chapter examines what's happening in media, including non-news media, and also explains why media coverage of HIV/AIDS is criticized.

Milestones

CO-PRODUCTION INITIATIVE

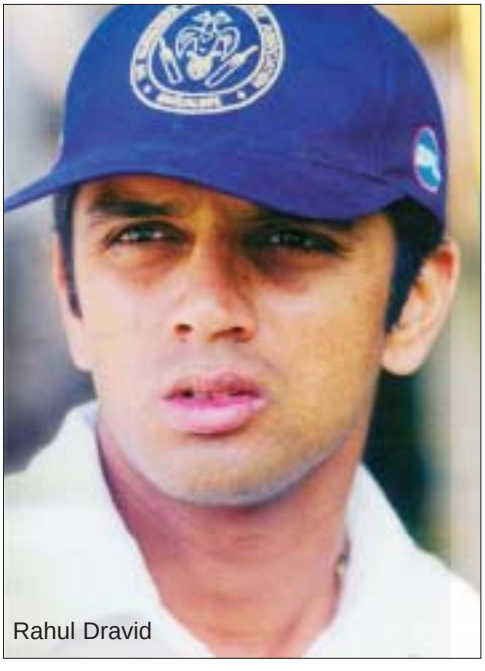
India's state broadcaster, Doordarshan, is one of 14 national broadcasters who came together in August 2005 to co-produce television programmes on HIV/AIDS. Participating broadcasters will create segments to be packaged together as 'HIV/AIDS Reports', which will air in the different countries. The reports will focus on the implications of the epidemic with emphasis on the human or social dimension. The initiative was organized jointly by the Asia-Pacific Broadcasting Union (ABU), UNDP, UNAIDS, UNICEF, MTV International, and the Kaiser Family Foundation.

THE HEROES PROJECT

The Heroes Project, which was launched by Richard Gere and Parmeshwar Godrej in July 2004, is a three-year campaign to produce and broadcast public service messages on HIV/AIDS in India. The initiative is funded by The Gere Foundation India Trust, the Bill and Melinda Gates Foundation, the Kaiser Family Foundation, and STAR India. The imaginatively produced television messages include:

Richard Gere

- **Dressing Room**, featuring cricketer Rahul Dravid padding up for the pitch and delivering the message that it would be foolish to not use protection: "Use a condom. Every time";
- **Fans**, Dravid mixing with fans: "AIDS cannot spread with a touch, but what a touch can spread is a lot of happiness";
- **Two Flowers and a Game of Carom:** Young couples who end up doing things other than they set out to do: "No condom, no sex";
- **It Can Happen to Anyone:** Anchored by actor Amitabh Bachchan, it shows people from different classes saying it doesn't happen in our society: "Inform yourself, get to know more about AIDS";
- **Let's Talk about AIDS:** Also anchored by Amitabh Bachchan, shows a family man sending his children out of the room on errands when the subject of AIDS appears on television: "With knowledge, we can stop the spread of AIDS. So let's start talking about it with our families, within our homes"; and
- **Talking with Young People:** Mothers subtly attracting the attention of their children to a radio programme, magazine, and poster: "There are many ways to start a conversation, but the important thing is to talk to your children about HIV/AIDS".


Rahul Dravid

Bency and Benson's Battle against Discrimination

Bency and Benson came into the media spotlight in 2003, when their quest for education became a national question mark. Bency, then 7, and Benson, then 5, were born to HIV+ parents in Kerala, who died within a short span of each other, leaving the children to be brought up by their maternal grandparents.

When five schools refused the children admission because they, too, were HIV+, they and their grandfather went on a day-long fast outside Kerala chief minister A K Antony's office. Antony intervened on their behalf and got them admitted into the government school at Kollam. However, the parents of the other students in the school protested, and kept their children away from school.

Finally, Kerala education minister Nalakath Soopy announced that Bency and Benson would be schooled at home at the state government's expense. Later, the President of India, A P J Abdul Kalam, also met the children and their grandfather.

In April 2005, Bency and Benson were on the cricket pitch in Kochi—shaking hands with captains Saurav Ganguly and Inzamam-ul-Haq before a one-day international between India and Pakistan. Kerala has one of the highest literacy levels among the states of India, which is why the depth of ignorance about HIV/AIDS among the people there, as evidenced in the ostracism of Bency and Benson, was so shocking.

JASOOS VIJAY AND HAATH SE HAATH MILAA

In 2002, Doordarshan, the National AIDS Control Organization (NACO), and the BBC World Service Trust joined hands to produce television programmes—the detective drama, *Jasoos Vijay*, and a reality show called *Haath Se Haath Milaa*.

Farhan Khan as *Jasoos Vijay*

This was the first mass-media campaign on HIV/AIDS in India and was hugely successful. The award-winning *Jasoos Vijay*, which is estimated to have reached 125 million people, returned in September 2005 to a prime-time slot on Doordarshan National in Hindi and seven other languages.

SOAPS

Though HIV/AIDS has not impacted the story lines of soap operas on Indian television, "socially responsible" soaps have attracted viewers and listeners and helped educate them in many countries. In Brazil, home of the 'telenovela', *Malhaçao* (*Working Out*) dealt with issues facing young people. One of the most keenly watched programmes in Nicaragua is *Sexto Sentido* (*Sixth Sense*), a hard-hitting programme that tackles sexuality, rape, domestic violence, and substance abuse. When NHK in Japan aired a serial called *Kamisama Mo Sukoshidake* (*Please God, Just a Little More Time*), about a schoolgirl who was infected after becoming a sex worker, the number of HIV tests and requests for counselling more than doubled. In China, *Bai Xing* (*Ordinary People*) follows the struggles of a family as they tackle many issues, including HIV/AIDS. *Bai Xing* has proved a popular and award-winning show. In Tanzania, Uganda, and South Africa, radio has proved a powerful medium.

MTV'S STAYING ALIVE

Staying Alive began on MTV in 1998 as an Emmy award-winning documentary profiling the lives of six young people from around the world infected with or affected by HIV/AIDS. Growing from the tradition of annual documentaries, *Staying Alive* has expanded to a multi-tiered international campaign to promote awareness about HIV/AIDS. It's the single-largest ongoing global HIV/AIDS awareness and prevention campaign for young people.

Campaign Gone Wrong

HIV/AIDS is a sensitive subject, and good intentions may not be enough to prevent causing offence. In February, 200 hoardings put up in five cities in Uttar Pradesh had to be taken down because they were insensitive and stigmatizing. They had been put up by the UP State AIDS Control Society and UNICEF. The messages they put out met with strenuous objections—one of them said: "Hero or Zero? How smart are you? Keep away from AIDS". Other hoardings used phrases from Hindi movies: "*Khiladi ya Anadi* (Skilled or Novice?)", "*Dil Chahta Hai* (The Heart Desires)", and "*Kal Ho Na Ho* (There May Be No Tomorrow)". Activists and PLWHA made the point that to equate the HIV+ community with "Zero" or "*Anadi*" was to stigmatize them and to imply that they were somehow at fault.

In 2001, UNICEF had to withdraw an 80-page publication it funded, called *Caste-based Prostitution in India*, after it was pointed out that the booklet seemed to target a specific caste group in India as being given to pimping and prostitution and, therefore, as 'high-risk'.

BOLLYWOOD

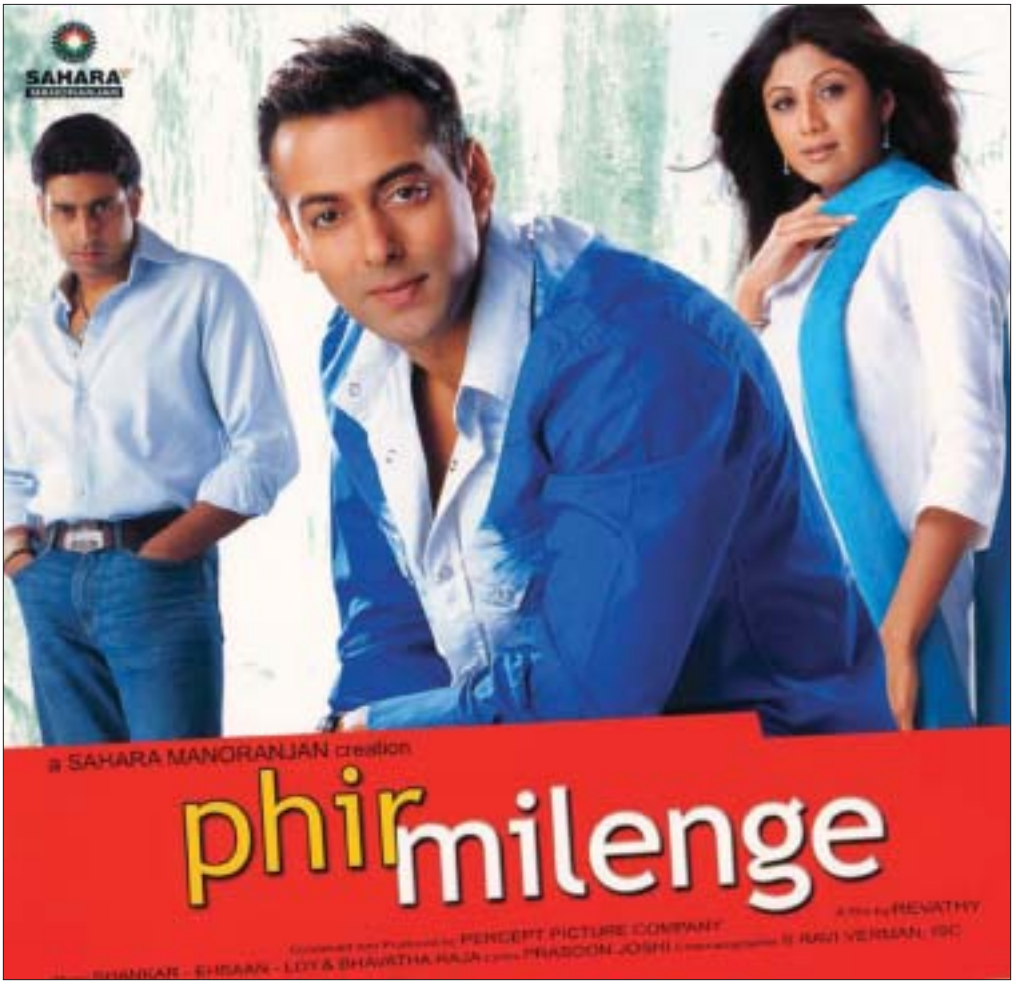
India's prolific film industry kicked into gear in August 2004 with the release of *Phir Milenge*, a film about a young advertising executive who gets infected by her boyfriend and her legal battle against discrimination at work. The film was entered for international film awards by UNAIDS. *My Brother Nikhil* was released in March 2005. In this film, the life of a young man from Goa during the early years of the epidemic is the vehicle for exploring misconceptions about HIV/AIDS and its effect on relationships.

INTERNATIONAL FILMS

Hollywood and other film industries, including the Italian and French, have produced at least a dozen films that deal with HIV/AIDS. Perhaps the best-known in India is the 1993 film, *Philadelphia*, which features Tom Hanks as a lawyer who faces workplace discrimination. Stories centring on the epidemic began to be filmed in the mid-1980s: *An Early Frost*, *Parting Glances*, and *Longtime Companion* are some of the early films. Many of them have been about gay men, reflecting the early mislabelling of HIV/AIDS as the "gay plague".

SPORTS EVENTS

Sports has proved to be an effective means of raising awareness about HIV/AIDS. The Buladi Para Football Tournament 2005, held in August in Kolkata, was used as a vehicle to raise awareness about the syndrome by the Indian Football



Association (IFA) and the West Bengal State AIDS Control Society. At each match venue were information stalls and counsellors, who interacted with people, telling them about safer sex and demonstrating the use of condoms.

Buladi is an animated character representing a 30-year-old, middle-class housewife, and she has appeared on billboards, radio, and television, answering questions related to HIV/AIDS.

Cricketer Rahul Dravid began promoting the fight against HIV/AIDS in July 2003 as a member of the India AIDS Initiative Board of the Bill and Melinda Gates Foundation. In August 2005, Dravid and two of his teammates, Irfan Pathan and Harbhajan Singh, took time out from their tour schedule in Zimbabwe to meet and play with orphans at a UNICEF-supported education project outside Harare. One in five Zimbabwean children is now an orphan due to HIV/AIDS.

The PLWHA Perspective

The Indian Network for People Living with HIV/AIDS (INP+) has observed that the amount of media coverage on various aspects of HIV/AIDS has increased noticeably during the last decade, but there has been little change in the images of the epidemic that are conveyed by the media.

"The coverage continues to dwell on disempowering images of death, despair, stigma, abandonment, marginalized groups, or mismanagement of funds or programmes. Though the presence of sensitized media persons is increasing, sensation is still the key word ruling coverage. Stereotyped reporting patterns and stereotyped sources continue to cause further discrimination of PLWHA," says the group.

"Harmful stereotypes are portrayed indiscriminately. Stories such as 'PLWHA stoned to death', 'PLWHA committing suicide', 'The prisoner who is HIV+', 'Husband infects wife without revealing his HIV status', and so on contribute to promoting a negative image about PLWHA. Words with negative associations, unnecessary dramatization, and pity are widely used by the vernacular media," it adds.

Reporters' sources and the inclination to depend on a well-known, but limited, bank of sources such as NGOs and some HIV/AIDS experts were pinpointed as problem areas. A disproportionate amount of media coverage is devoted to pre-arranged events and programmes, with a heavy leaning towards celebrity attended events.

WHAT PLWHA FIND MISSING FROM MEDIA REPORTS:

- The economic cost of HIV/AIDS;
- The social cost of HIV/AIDS;
- The medical cost of AIDS;
- The politics of HIV/AIDS;
- Independent investigative coverage;
- Adequate research; and
- Reports on the availability of ARV drugs and other health facilities for PLWHA.

WHAT PLWHA WOULD LIKE TO SEE THE MEDIA DO:

- Maintain confidentiality;
- Refrain from sensationalism because it only creates negativity on all sides;
- Avoid understatements and

exaggerations;

- Avoid inappropriate or outdated terminology—the language of 20 years ago is still being used by some people;
- Avoid using alarm and fear to alert your audience—not only are they outdated, they fuel stigma and distrust;
- Update your knowledge;
- Research your stories;
- Go beyond the news imperatives and explain the human dimensions of the issue;
- Build partnerships with those affected by the epidemic; and
- Advocate the rights of people living with the epidemic.

Issues of Confidentiality

Extracts from a letter by Usha Dey from the Assam Network for People Living with HIV/AIDS:

"On World AIDS Day, December 1, 2004, the counsellor of Dibrugarh VCTC invited us to the centre, saying that the principal of Dibrugarh Medical College and doctors would be present, it will be good for you if you come. At the centre, the doctor and four others started asking questions like, When did you get it? How did you get it? We started to share about our life as usual, thinking that they were all doctors.

They said they will send our photographs to the chief minister and the health minister so that we can get some assistance from the government. We also noticed a man shooting with a video camera. I thought: 'My economic condition is so bad, and my husband's CD4 count is only 63 and he has still not started ARV due to lack of money.' Therefore, allowed them to take our photographs.

The next morning we woke up and saw that two newspapers had printed stories about us. We were shocked and realized that the previous day's discussions were part of a drama. A popular TV channel, too, carried a story. They changed our names, but not the location.

They exploited and humiliated us, brought upon us the wrath of our community. We earned through a small shop. But after this incident, nobody is coming to our shop, which is affecting our earnings. My four-year-old child's friends have deserted him. Nobody wants to play with him. When my son went to school, the staff did not allow him to go inside the classroom and he had to sit outside."

THE ETHICS OF REPORTING ON HIV/AIDS

I wonder what if our presence was visible by some geographical nearness? The number of People Living with HIV/AIDS in India is much more than many of the North Eastern states. The total population of the states of Manipur and Meghalaya combined is only 4.4 million, where-as we are 5.1 million, yet it seems our lives are less important for the media's eyes and ears.

— **Daisy David**
PLWHA

HIV/AIDS is a story of critical importance, and audiences deserve full, clear and intelligent coverage. Journalists should cover it with imagination and initiative, and commit themselves to the highest ethical standards.

The guidelines below outline some key principles to adhere to in striving to attain high ethical standards in reporting on HIV/AIDS. They include adaptations from materials developed by a host of journalists and institutions, including Franz Krüger and the African Women's Media Centre.

BASIC PRINCIPLES IN COVERING HIV/AIDS

Accuracy

- Get scientific and statistical information right;
- Check facts;
- Ask about sources of statistics and their reliability;
- Provide dates for data or statistics, check on the currency of information;
- Use credible sources to verify facts and interpret information;
- Name sources as often as possible;
- Reflect tentativeness of research if it is not conclusive evidence;
- Write stories in context; and
- Tell a complete story, not just one side or one part of a story.

Balance

- Give due weight to the story;
- Cover all aspects, including medical, social, political and economic; and
- Highlight positive stories where appropriate, without underplaying the seriousness of HIV/AIDS.

Clarity

- Accurately reflect which side of an argument carries more or less weight and why;
- Never assume that the audience knows anything even mildly technical about the HIV/AIDS story, but don't assume that your readers/listeners/viewers are ignorant, either; and
- Make statistics and science accessible and relevant to audiences.

Demand Accountability

- Demand accountability from the government, the pharmaceutical industry and advocacy groups in their handling of the epidemic; and
- Engage with, but do not be captive to, any interest group.

Show the Human Face of the Epidemic

- Ensure that the voices and images of people living with and affected by HIV/AIDS are heard and seen; and
- Take care that the voices heard are diverse, and include those of women and men, and vulnerable and marginalized people.

Respect the Rights of People with HIV/AIDS

- Vulnerable people should be treated with particular care;
- Clearly identify yourself as a media person;
- Seek explicit permission before using someone's name, story, or image;
- The purpose of the interview or photograph and the context in which these may be utilized should be stated;
- Seek to understand the possible consequences for individuals who participate in your report and ensure that they, too, are clear about the consequences;
- Promises of confidentiality must always be honoured; and
- Only in cases of overwhelming public interest can somebody's HIV

status be reported against their wishes or should journalists hide their professional identity.

Dealing with Children

- Children experience the most extreme consequences of the epidemic, and their rights to privacy should be afforded even greater protection;
- Children often do not realize that they have the right to refuse to be interviewed or identified;
- They should only be identified if the public interest is overwhelming, and then only if no harm to them is foreseeable;
- Seek the informed consent of the children as well as their parents or guardians;
- Children have the right to participate in decisions affecting their lives; and
- They also have the right to be heard, and journalists should ensure that their concerns are covered.

Sensationalism

- Report the facts, don't just dwell on the negative;
- Avoid morbid and sensational language, especially in headlines; and
- Remember that HIV/AIDS and its contexts are not entertainment.

Empower, Don't Victimize

- People living with HIV/AIDS should not be stereotyped as irresponsible, as it is often untrue;
- Classifying some as "innocent" means classifying others as "guilty"; and
- People living with HIV/AIDS are not victims. Portraying them as victims assumes that they are helpless and unable to make their own decisions, which is false.

Avoid Fuelling Stigma and Discrimination

- Particular care should be taken not to use language or images that reinforce stereotypes; and
- Identify behaviour that puts one at risk rather than the type of person that may be at higher risk.

Handling the Bereaved

- Those who are mourning the loss of their loved ones deserve respect; and
- It is inappropriate to force a microphone or a camera into the face of a mourning relative.

Respect Cultural Practices

- Discuss sex and other sensitive issues respectfully, but openly; and
- Ensure that language, cultural norms, and traditional practices relating to, for example, inheritance and sex, are understood and accurately reported.

Misconceptions

- Claims of cures or treatments should be reported with due care; and
- Look at all stories critically.

ACCOUNTABILITY

- Be prepared to defend your decisions.

TRUTH-TELLING

In some senses, the first and most basic principle of reporting on HIV/AIDS is accuracy. In the context of HIV/AIDS, this means that journalists need to be very careful about the science involved, which is sometimes very complex. Statistics are also written about often, and again journalists need to be careful to get them right.

In a broader sense, the truth-telling principle means telling the story fully and giving it due weight. This means reporting the epidemic in a nuanced way, and investigating the social, medical, personal, scientific, economic, educational, political, and other aspects of the issue. That kind of balance won't be achieved in a single story, but it can be achieved over time.

THE GENDER DIMENSION

It is particularly important to report with due regard to the gender dimensions involved. Journalists should make sure that women's voices are heard, and investigate the ways in which the epidemic is affecting women and girls differently to men and boys. A gender dimension can be found in almost any story.

In a more general way, a gender perspective of HIV/AIDS points to the need to report on wider gender inequalities that fuel the epidemic, on issues like gender violence, transactional sex, and much else.

That gender perspective should also lead journalists to consider the general question of media representations of men and women, and make sure their reporting undermines rather than fuels harmful attitudes.

Gender is an important part of the context, without which the epidemic can't be properly understood.

POSITIVE STORIES

The call is sometimes made not to report the story purely in terms of gloom and doom. It's a legitimate point, and opportunities to report "positive lives"—stories of people living positively with HIV/AIDS—should be taken.

Telling the whole story means giving the epidemic a human face.

Buladi props up the awareness campaign in West Bengal on World AIDS Day, 2004

NEWS VALUES

There is a fundamental problem that often stops journalists from covering this story fully, and it arises from their own news values. The story of HIV/AIDS does not always fit easily into those values, which call for drama, conflict, and the like.

But there are options. Normal news values are not as rigid as they are sometimes made out to be. Journalism is a craft that values inventiveness, even though that may sometimes be hard to see in the grey expanse of everyday coverage. The classic hard-news story may not easily lend itself to coverage of the epidemic. But there are other formats—it is often just a question of being inventive or original.

INDEPENDENCE

This means keeping a distance from the various players in order to be able to report honestly and maintaining healthy scepticism towards the government, pharmaceutical industry, and activist groups. Some journalists interested in the issue find themselves siding with activist groups. But they should be wary of these, too. A whole industry has developed around AIDS, and these groups need to be held to account as much as anybody else.

Journalists should not accept payment for writing stories, except of course from their employers.

PRIVACY

In concrete terms, privacy means taking great care when it comes to reporting on people's status. Their story, the way their family deals with the situation, medical details, photographs—all of this belongs to their private sphere, over which they have control.

The issue has a particular slant where, as is so often the case, journalists are dealing with people who are poor and disadvantaged. They need to take particular care not to bulldoze people, pushing them into doing something they may not really want to do.

FIGHTING STIGMA AND STEREOTYPES

Reporting—along with other forms of media representation—may perpetuate harmful social attitudes. If journalists always illustrate stories about HIV/AIDS with pictures of poor people, they are perpetuating a stereotype about the syndrome that is both inaccurate and harmful. If they focus unnecessarily on how people were infected, they may reinforce an attitude that seeks to blame those with HIV or AIDS for being infected.

What is required is a balanced representation. This means taking care with generic images, where a general, non-specific picture is used to illustrate a report. These should, over time, reflect the different kinds of people who may be affected.

Reporting should also not reinforce a "them/us" mentality, where people with HIV/AIDS are seen as a separate species, a problem to be dealt with. Society needs to understand that everyone is affected in one way or another.

OPENNESS

Even though it is generally wrong to force people to disclose their status, there's nothing wrong with encouraging openness. Where prominent people have disclosed their status, they have generally received a lot of positive publicity. In doing so, the media (and they, of course) supported the principle of openness.

Many of our leaders passed away silently. Leaving us in tears and loss. But their efforts were passed on. They live in our hearts and keep the movement going... We remember them today,

celebrating their life,
celebrating their contribution,
and celebrating their courage.

THE LANGUAGE OF HIV/AIDS

PEOPLE living with HIV/AIDS already suffer considerably from the stigma, prejudices, misconceptions, and fears that surround the syndrome. While reporting news about them, therefore, it is important that journalists remember to keep in check their personal biases and ensure that their language does not portray ignorance.

At the same time, the language media persons use in their reports helps shape attitudes about HIV/AIDS. Therefore, they must learn language that is appropriate to the HIV/AIDS epidemic.

While HIV/AIDS has huge social and emotional ramifications, it has aspects that are intensely technical. Thus, it is important to not only try and understand the technical issues involved, but also to ensure that the information conveyed through news reports is not technically flawed.

What is appropriate language in the context of reporting on HIV/AIDS?

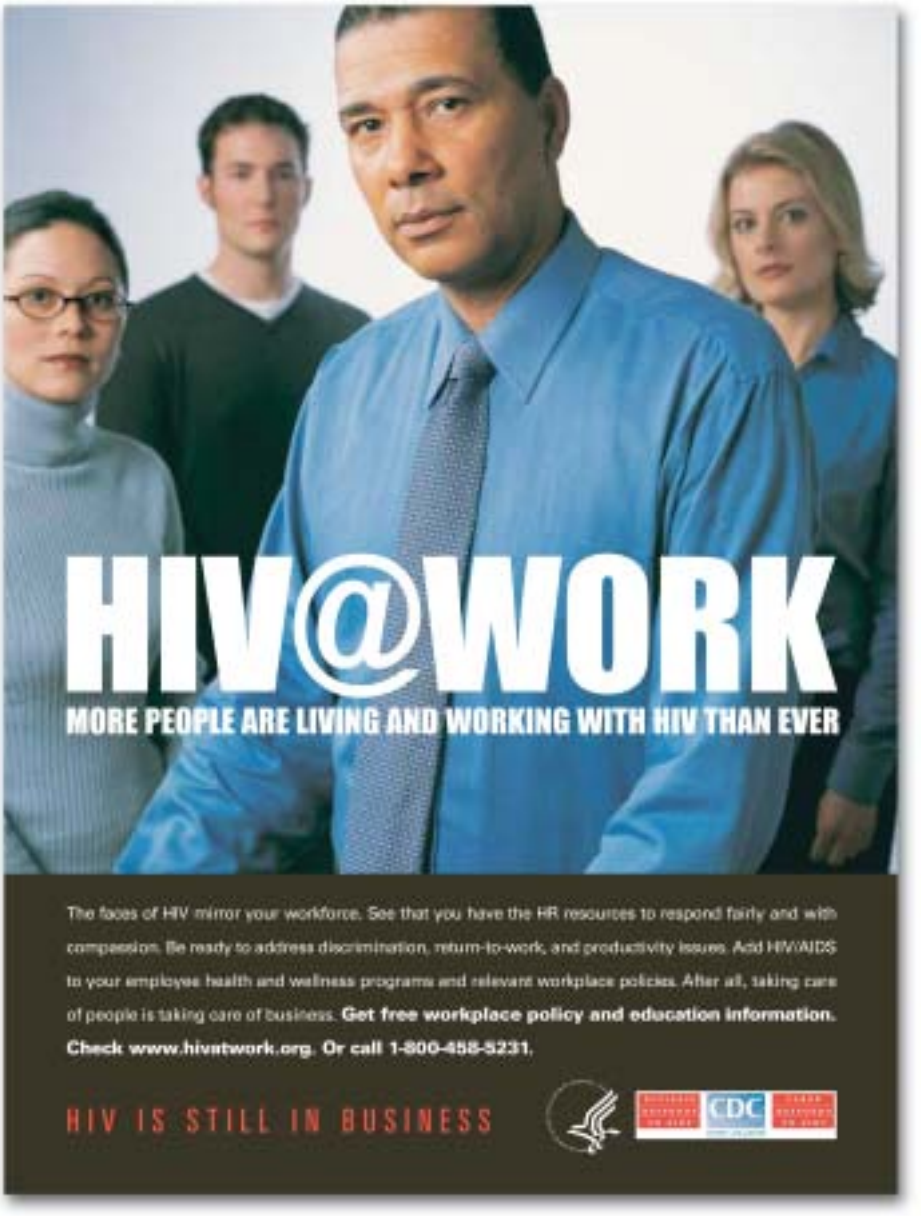
- Appropriate language is constructive;
- It avoids sensationalism of all kinds;
- It does not fuel stereotypes;
- It does not cause prejudice or fuel stigma;
- It is suitable to the audience. This requires journalists to be familiar with their audience as well as fluent in HIV/AIDS terminology;
- It is non-judgemental and non-discriminatory;
- It is positive and empowering, rather than victimizing;
- It is neutral and gender sensitive; and
- It is technically accurate, but distils technicalities into an easily understood form.

Writing with Sensitivity

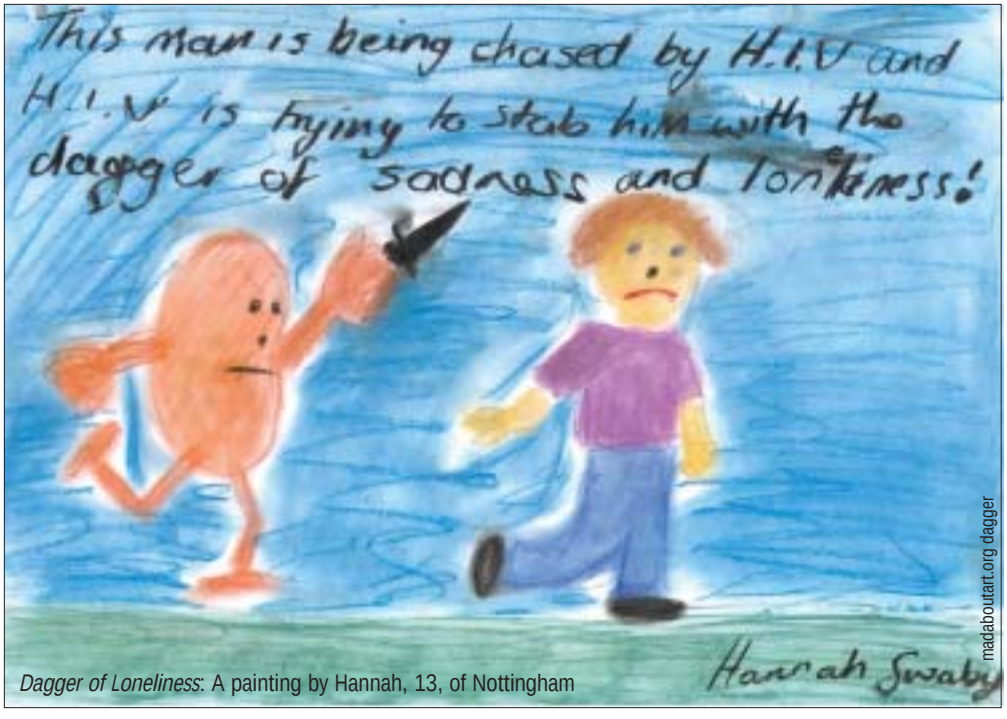
AVOID ✗	BECAUSE ?	USE ✓
Aids	Aids already means many things. AIDS is an acronym for Acquired Immune Deficiency Syndrome	AIDS
HIV and AIDS **HIV or AIDS**	HIV and AIDS are linked. HIV leads to AIDS	HIV/AIDS
AIDS virus	Can cause confusion between HIV and AIDS	HIV
HIV virus	HIV is an acronym for Human Immunodeficiency Virus, so virus is already included in the term	HIV
AIDS scourge/plague	Sensationalist; implies that HIV/AIDS cannot be controlled; may fuel panic, discrimination, and hopelessness	HIV epidemic
The disease of AIDS	AIDS is not a disease. It is a syndrome (group of illnesses) that results from a weakening of the immune system by HIV. This opens the body to "opportunistic" diseases (illnesses that take advantage of weak immunity)	AIDS-related illness Name the specific illness, such as TB or cancer
Full-blown AIDS	No need to use if correct distinction is always made between HIV and AIDS; there is no half-blown AIDS	AIDS
AIDS test	There is no test for AIDS, but there are tests for HIV	HIV antibody test
Catch HIV	No one can catch HIV; people can become infected Transmission of HIV is also correct, but it emphasizes "who" and how the virus is transmitted, which, often, HIV+ people do not know	Contract HIV Become HIV positive
Catch AIDS	AIDS can't be "caught"	Develop AIDS Person living with AIDS
Carrying AIDS **AIDS carrier** **AIDS positive**	This confuses the two distinct phases of being infected with HIV and having AIDS. A person can have AIDS, but can't carry it	HIV positive Person/people living with HIV/AIDS
Safe sex	No sex with a partner is ever completely risk-free, even when using a condom, which can greatly reduce, but never fully eliminate, the risk	Safer sex
Bodily fluids	Not all bodily fluids transmit HIV	Semen; breast milk; blood; vaginal fluids
HIV victim/sufferer	Victim connotes powerlessness—PLWHA are definitely not victims	PLWHA HIV positive person

Writing with Sensitivity

AVOID ✗	BECAUSE ?	USE ✓
AIDS sufferer	Many people with HIV/AIDS can enjoy relatively good health for years, and lead happy lives	PLWHA HIV positive person
AIDS patient	Only appropriate when someone is ill. Care is needed to distinguish this from HIV infection, when "patient" is not appropriate. The word patient should be used when referring to the clinical setting only	People living with HIV/AIDS Person living with HIV/AIDS
Innocent	It implies someone else is guilty. No one chooses or deserves to contract HIV	AVOID USING THIS AT ALL
Prostitute	Considered value laden and derogatory	Sex worker
Promiscuous	Accusatory and derogatory	Having multiple partners
Drug abuser/addict	Many people who use drugs consider that they are in control of their use of drugs, that they are not addicted to them. Calling them abusers/addicts alienates them, which serves no good purpose. It is the act of injecting with a contaminated needle, not the drug use itself, that transmits HIV	Intravenous drug user (IDU)
Homosexual	This is a Western idea of one's identity. In different regions of the world, men who have sex with men do not necessarily have a gay or homosexual identity	Males who have sex with males (MSM)
High-risk groups	There is high-risk behaviour, but no high-risk group. Regardless of the group he belongs to, it is what a person does that exposes him to HIV	High-risk behaviour


HIV@WORK
MORE PEOPLE ARE LIVING AND WORKING WITH HIV THAN EVER
The faces of HIV mirror your workforce. See that you have the HR resources to respond fairly and with compassion. Be ready to address discrimination, return-to-work, and productivity issues. Add HIV/AIDS to your employee health and wellness programs and relevant workplace policies. After all, taking care of people is taking care of business. Get free workplace policy and education information. Check www.hivatwork.org. Or call 1-800-458-5231.
HIV IS STILL IN BUSINESS
CDC

TELLING THE STORY



Dagger of Loneliness: A painting by Hannah, 13, of Nottingham

THE canvas of HIV/AIDS lends itself to great stories. That is, once you stop treating it as just a health story. HIV/AIDS not only deals with life and death, and conflict and controversy, it encompasses a host of social, economic, political, and developmental stories. Add to this sexuality, science, psychology, misconceptions, trends, law, industry, and policy, and a heady palette of possibilities emerges.

Unfortunately, in reality, most stories on HIV/AIDS tend to fit into a limited number of neat categories—event coverage, press releases, advocacy, and PLWHA issues. The reason often given is that editors and producers turn down story ideas put forward by reporters.

This chapter presents suggestions on how to generate great story ideas and to get them approved by your editor or producer. They have been compiled from the experiences of a host of journalists, editors, and producers, The African Women's Media Centre, and speeches and writings on reporting HIV/AIDS.

Story Ideas

- New Trends in the HIV/AIDS Epidemic
  - What population groups are being hit the hardest, why, and who is doing what to respond.
- Mapping the Epidemic
  - How it is moving from one community to another. For example, how the epidemic is moving along truck routes or between migrant workers and their homes;
  - How it is being transmitted;

Even after an HIV+ person dies, people are often scared to touch the body, making the last rites a problem.

— SOCIAL WORKER IN KARNATAKA

- How it could be stopped; and
- Trends in other countries.

Social Attitudes and Cultural Norms

- Attitudes to sex and sexuality;
- Attitudes as reflected in governmental policy;
- Fears of various kinds; and
- Trends.

Issues of Confidentiality and Disclosure

Traditional Gender Roles and Relationships and HIV/AIDS

- How being a wife puts a woman at risk for HIV/AIDS;
- How gender affects care for women; and
- How empowering women can prevent HIV/AIDS.

HIV/AIDS, Human Rights, and Justice

- Rights of people with HIV/AIDS and the legal protections for people with HIV/AIDS;
- How people with HIV/AIDS are treated and how they should be treated; and
- International conventions/plans of action related to human rights, reproductive health, gender equality, children's rights, etc., and the status of their implementation.

Adolescents or Young Adults and Their Risk for HIV/AIDS

The Impact of HIV/AIDS on Schools and Universities

- The impact on teachers and students; and
- The role of teachers in overcoming the epidemic, and examples of what is being done.

The Impact of HIV/AIDS on Family Structures and Relationships

HIV/AIDS and Children

- Maternal transmission of HIV and its prevention;
- AIDS orphans—the extent of the problem and the impact on older generations;
- The changing roles of older generations in the face of HIV/AIDS; and
- Strategies to care for AIDS orphans and others affected by HIV/AIDS.

The Impact of HIV/AIDS on Different Sectors of the Economy

- For example, its impact on different businesses, industries, agriculture, or in particular areas; and
- What this impact means for economic and social development.

Sex Work

- What health services and governments are doing—or could do—to make sex work safer for workers, clients, and their families;
- Programmes for sex workers and their clients—what works and what doesn't; examples of empowered sex workers and leaders in the workers' communities;
- Economic conditions and gender disparities that fuel the sex industry; and
- Viable economic alternatives to sex work (e.g. micro-credit programmes).

The Response of Religious Leaders and Communities to HIV/AIDS

The Healthcare System in India

- Delivery of free anti-retroviral drugs;
- Testing;
- Counselling;
- Care; and
- Attitudes towards patients within the healthcare system.

Treatment and Care of People with HIV/AIDS

- AIDS therapies/medicines, including their availability;
- Government policy; and
- Costs and challenges surrounding AIDS therapies.

Drug Resistance and Its Implications

Research into HIV/AIDS Vaccines; Vaccine Trials

Misconceptions about HIV/AIDS or Fraudulent Claims of Cures

The Pharmaceutical Industry

- Processes and patents;
- Costs of drugs;
- Research;
- Financial provisions for research; and
- The export of ARV drugs.

Legal Issues

- Rights;
- Patents; and
- Discrimination.

Statistics and Their Correspondence with Reality

- Methods of collecting nationwide figures and statistics;

AIDS crosses: From the Siyazama Project (1999-02) by Zach Goldman

- Conflicting and inconsistent figures or findings; and
- Projections.

Human Interest

- The lives of people connected with HIV/AIDS by profession, relationship, or health;
- Experiences of those to whom the audience can relate; and
- The stories of achievers.

Movies and the Media

- Policy Issues
  - International action plans and concerns;
  - Governmental policies, including those of donor nations, and their effect;
  - Consultations on future initiatives; and
  - How policies are developed, whose voice is heard, and who remains unheard.

- The Role of Institutions
  - Are governments and institutions implementing their plans?
  - Are they implementing their plans on schedule?
  - Are they achieving their objectives? What evidence is there?
  - Who benefits from the plan?

- The Flow of Money
  - Are the funds getting to the people they are supposed to benefit?
  - Are the funds being used effectively?
  - Are the funds being used efficiently?
  - Are funds lying unused?

Overcoming Editorial Barriers

One of the greatest challenges in covering HIV/AIDS issues is selling story ideas to editors and senior producers who decide which stories make it and which don't, and which should get prominent space or airtime.

Some of the barriers are:

- Editors are tired of covering HIV/AIDS. They say that they have "been there, done that", and that it is not news any more;
- They may be under the impression that their audience is already adequately informed about HIV/AIDS; and
- There can be stiff competition for print space or airtime, making it difficult to slot in substantial stories on HIV/AIDS, or to do so on a regular basis.

Here are some simple strategies that have been used successfully by journalists from different regions of the world:

Editorial Barriers	Strategies for Overcoming Obstacles
Editors consider topics dealing with health, science, or social trends as "soft", and not newsworthy.	General strategy: Package the stories well. Be creative. A brilliant story about a topic that may have sounded dull to an editor will sell. Find a new hook/peg for the story. Link the HIV/AIDS story with some current event(s) or with policy/politics. Work with information sources, such as non-governmental organizations, to get useful and timely information on

	a regular basis. Delve into the topic, and cover it in greater depth than has been done before. Plan stories for idle news days when they are more likely to get print space or airtime. Point out coverage of HIV/AIDS in competitors or other media to your bosses
Editors think that HIV/AIDS . is an old story.	HIV/AIDS is no more an old story than politics is a tired story. Investigate the myriad aspects of HIV/AIDS. Take a different approach to reporting on HIV/AIDS. Often, coverage of HIV/AIDS is sensationalist, alarmist, and gloomy. Change this. Look at promising initiatives, success stories, acts of courage, and people who are making positive changes. In preparing or proposing a story, think about why and how this particular aspect of HIV/AIDS is newsworthy. Identify what is new, such as new studies or data, developments in programmes fighting HIV/AIDS, social changes brought about by HIV/AIDS, progress in the pharmaceutical industry.
Certain aspects of HIV/AIDS, including some of the language, may be culturally shocking.	Survey audiences to find out what they are really interested in, and what they are willing to hear or read.
Editors and managers—possibly reflecting an important segment of the public—may be afraid to deal with a particular issue.	When covering a controversial issue or a harmful practice that is traditional, listen to all sides. Make sure the coverage is balanced. Use ethics, judgement, and common sense as a guide. Use non-judgemental, clear, concise language. Use the terms recommended by those working in the HIV/AIDS field.
Editors and managers have a formula that works for them in making editorial decisions, and new HIV/AIDS stories may not appear to fit into that formula.	Find a news angle that will justify using the story.

Source: The African Women's Media Centre

"We know treatment is our life and right."

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www.nacoonline.org

Parliament of India
www.parliamentofindia.nic.in

National Aids Research Institute
www.icmr.nic.in/pinstitute/nari.htm

Tuberculosis Control-India
www.tbcindia.org

UNAIDS
www.unaids.org For press enquiries only: Isaac Thalar nthalari@yahoo.co.in

Global Fund to Fight AIDS, TB and Malaria
www.globalfundatm.org

WHO's Global HIV/AIDS Programme
www.who.int

United Nations Development Programme (UNDP)
www.undp.org

Centers for Disease Control and Prevention
www.cdc.gov

United Nations Population Fund
www.unfpa.org

Population Council
www.popcouncil.org/horizons

AEGIS
www.nacoonline.org

Ministry of Health & Family Welfare
www.mohfw.nic.in

Indian Council of Medical Research
www.icmr.nic.in

International Aids Vaccine Initiative
www.iavi.org

National Institute of Communicable Diseases
www.nicd.org

Bill & Melinda Gates Foundation
www.gatesfoundation.org/default

WHO Representative to India
www.whoindia.org

World Bank
www.worldbank.org

USAID in India
www.usaid.gov/pop_health/aids

Family Health International in India
www.fhi.org/en/cntr/asia/india/indiaofc.html

UK Development (DFID)
www.dfid.gov.uk

AIDS Education and Research Trust
www.avert.org

The Body
www.thebody.com

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